Board of Directors: Public Session

Schedule	Thursday 2 February 2023, 9:30 AM — 12:00 PM GMT
Venue	Via Zoom
Organiser	Jane Mudd

Agenda

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	Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final. In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	448
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1. Introduction

1.1. Welcome and Apologies

Observing: Cathy Hassell Managing Director, Acute Federation

To Note

Presented by Sheena McDonnell

1.2. Declarations of Interest

To Note

Presented by Sheena McDonnell

1.3. Quoracy

To Note

Presented by Sheena McDonnell

1.4. Minutes of the Meeting held on 1 December 2022

For Approval

Presented by Sheena McDonnell

Minutes of the meeting of the Board of Directors Public Session
Thursday 1 December 2022 at 9.30 am, via zoom

Due to the current Covid-19 pandemic, the meeting was not held in a public place. In the interests of maintaining transparency and openness during Covid-19, the meeting was live-streamed via YouTube, and a recording of the meeting was placed on the Trust's website.

PRESENT:	Mrs S McDonnell	Chair
	Dr R Jenkins	Chief Executive
	Mr B Kirton	Chief Delivery Officer/Deputy Chief Executive
	Mr C Thickett	Director of Finance
	Mrs J Murphy	Director of Nursing & Quality
	Mr S Ned	Director of Workforce
	Mr S Radford	Non-Executive Director
	Mrs S Ellis	Non-Executive Director
	Mr K Clifford	Non-Executive Director
	Mr N Mapstone	Non-Executive Director
	Mr D Plotts	Non-Executive Director
	Mr H Zaman	Associate Non-Executive Director
IN ATTENDANCE:	Ms L Burnett	Director of Operations
	Mr T Davidson	Director of ICT
	Ms E Parkes	Director of Communications & Marketing
	Mr G George	Interim Director of Corporate Governance
	Mr J Griffiths	Deputy Medical Director
	Miss L Watson	Corporate Governance Manager *(minute taker)*
APOLOGIES:	Dr S Enright	Medical Director
	Mr P Hudson	Non-Executive Director

	INTRODUCTION	
BoD 22/111	**Welcome & Apologies** Mrs McDonnell welcomed members and attendees to the public session of the Board of Directors (BoD) meeting. Apologies were noted as above.	
BoD 22/112	**Declarations of Conflicts of Interest** The standing declarations of interest were noted from Dr R Jenkins, Chief Executive Officer, and Mr S Ned Director of Workforce for their joint roles between Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust. Standing declarations of interest were also noted from Mrs S Ellis and Mr K Clifford as directors of Barnsley Facilities Services (BFS).	
BoD 22/113	**Quoracy** Mrs McDonnell confirmed the meeting was quorate.	
BoD 22/114	**Minutes of the last Meeting** Subject to a minor amendment, the minutes from the meeting held on 6 October 2022 were reviewed and approved as an accurate record.	

BoD 22/115	**Action Log** All outstanding actions from the previous meetings were reviewed with satisfactory updates noted.	
BoD 22/116	**Staff Story: Clinical Assessment Unit/Paediatrics Emergency Department Development** Mrs Murphy introduced the video which was shared with the Board. The story was told by Gemma Malpass, Deputy Lead Nurse, based in the new Clinical Assessment Unit/Paediatrics Emergency Department Development. The video described the significant investment in Children's Services with the main focus being the Emergency Department (ED), Children's Assessment Unit (CAU) and the new build. The investments in the service highlighted improved recruitment and retention, investment in staff training/development, improved morale across the workforce and improved partnership working. All of these directly impact the patient journey which has improved significantly due to environmental and workforce factors. Dr Griffiths welcomed the new unit which provided a fantastic environment for both service users and staff; commenting that the purpose-built co-located facility makes a huge difference to service users and means the Trust can align its workforce ensuring the demands of patients are met. Vast improvements had been noted in paediatric patient care and also for staff working; by providing additional space for adult majors which was critical given the current pressures experienced with the urgent care pathway. Mr Kirton confirmed the Business Case and Evaluation Report will be presented to Board at a later date. The Board welcomed the story and was pleased to hear of the positive outcome for both patients and staff. Formal acknowledgment was made to the Clinical Operational Teams and the Estates Team at Barnsley Facilities Services for their hard work and support in the development of the CAU/ED.	
	CULTURE	
BoD 22/117	**Freedom to Speak up Guardian Report** Mrs Munford introduced the report providing an overview of activity during the second quarter of 2022/23. The Board was informed following the publication of several reports recently including The Kirkup Report and The Carr Review, as a guardian Mrs Munford was in the process of reviewing the findings and recommendations to see what the Trust can do to minimise risk within the organisation. Arising from the report the following key points were highlighted: • Since writing the report, by January 2023 there will be 20 trained champions within the Trust, significantly increased from last year. • The policy "Raising Concerns" is currently being revised in line with the national policy and guidance. It is expected the policy will be sign-off and available on the Trust Approved Document (TAD) page on the internet by April 2023.	

	• Work is ongoing with the Clinical Business Unit (CBU) leads on the eight outstanding actions; the target is to complete these by April 2023. • During the second quarter of 202/23, 28 contacts highlighting 29 concerns had been raised via the guardian and champions, a total of 79 concerns raised since April 2022, an increase on last year's figures. Consistent with previous reports the main theme remained to be behaviours, culture and attitude. • The Freedom to Speak Up (FTSU) review tool had been included for information purposes. Mr Radford suggested including triangulation of the staff survey results in the annual plan. Mrs Munford confirmed the results are triangulated into the report, working closely with Staff Side and Human Resources Business Partners to scrutinise the data. Mr George asked if the Trust is linking in with Integrated Care Board (ICB) Partners regarding themes in terms of system changes; asking if there are any actions the Trust could adopt. Mrs Munford confirmed the National Guardians Office had been approached asking how the system changes would affect the Trust. Several meetings had been held with the FTSU Guardian from The Rotherham NHS Foundation Trust and the ICB to share experiences and learn from each other. In response to a question about areas that may benefit from additional champions; Mrs Munford advised of no areas of concern. From a training perspective, all champions undergo a two-hour national teaching session which is provided by Mrs Munford, and informal peer support groups are held every four–six weeks, all support groups are bound by confidentially. The Board formally acknowledged and thanked Mrs Munford for her ongoing support, and was encouraged by the report and rising numbers of those speaking up which indicated the Trust's encouragement of a learning culture.	
	ASSURANCE	
BoD 22/118	**Quality and Governance (Q&G) Committee Chair's Log** Mr Clifford presented the chair's log from the meetings held on 26 October and 23 November 2023 which were noted and received by the Board. Reference was made to the patient experience, engagement and insight report; ***Action:*** *following discussion it was agreed the terminology describing the work relating to the "Always Events" was to be amended.* The Board referred to the staffing challenges experienced in the Pharmacy Department, asking what mitigations are in place to address staffing issues. Mr Clifford stated the Committee had received a detailed Clinical Pharmacy Service Critical Staffing update providing an overview of the challenges faced by the service. A recruitment plan and a skill mix review of staffing had been initiated to refocus the services provided by the Pharmacists and Technicians. Mitigations are in place to minimise risk to patients and service delivery. The impact of changes will be managed and overseen by CBU 3 and the Executive Team (ET).	KC

	Mr Hadar commented the inability to recruit was a national problem and has met with the Chief Pharmacist and Medical Director offline, to discuss and review alternative models of employment. A suggestion was made for the Quality Improvement (QI) work focussed on Pharmacy to be presented at a Board Strategic Focus Group session in the future. **ReSPECT Policy:** The ReSPECT Policy was received and approved by the Committee, with the recommendation for Board approval. The Board was informed the original implementation date of December 2022 had been deferred to March 2023. Dr Jenkins suggested the policy is presented at the next Barnsley Place meeting to ensure leaders in other areas are sighted on the policy. ***Action:*** *ReSPECT policy to be presented at the Barnsley Place Meeting.* The Q&G Committee will monitor and manage the action plan going forwards. The Board received and endorsed the policy and the need to engage more widely at Place for this to be delivered, and the new date of implementation was noted. **Annual Health and Safety Report:** The Health and Safety Annual Report highlighted the Fire, Health and Safety performance within the Trust from 1 April 2021 - 31 March 2022. Mrs McDonnell confirmed she would like this report presented annually for Board oversight. Reference was made to the increase in fire incidents and out-of-date fire safety risk assessments. Mr Kirton confirmed risk assessments are being completed and the team is working hard to ensure all are logged appropriately. Mrs McDonnell thanked the team for the informative report, commenting it would be helpful to understand the impact/gaps, risks associated with the fire assessments not being in place and any training gaps. The Board agreed to delegate this to the Committee. ***Action:*** *Mr Kirkton to delegate to Q&G.* The Board noted and received the report. **Annual NHS England (NHSE) Emergency Core Prep Standards:** The Trusts self-assessment against the NHSE Core Standards for Emergency Preparedness Resilience and Response was presented to Board for approval. As part of the improvement plan, NHSE had asked that all Gold/Silver Tactical Command Members attend and complete the Principles in Health Command programme. The objective of the learning is to provide leaders with knowledge and skills to lead or support the response to emergencies. The improvement plan for 2022/23 documented a plan to address the shortfalls by 31 March 2023, with progress monitored by ET. The Board received and approved the self-assessment and compliance statement.	BK BK
BoD 22/119	**Finance and Performance (F&P) Committee Chair's Log** Mr Radford presented the chair's logs from the meetings held on 27 October and 24 November 2022. The following points were highlighted:	

	• The Trust remains on track against the budgeted position, with an adjusted forecast of £8.8m deficit. The level of recurrency ratio had reduced from 59% to 38%. • The Committee discussed and reviewed the nine risks on the Board Assurance Framework (BAF). A meeting had been arranged to review splitting the risks between short and long-term within the current financial year, to ensure these are accurately articulated and on track. • An update was provided on the Pathology Business Case as the existing equipment is approaching its end of life. The central single Laboratory Information Management System (LIMs) across South Yorkshire had received £18m funding, which will be delivered to Teaching Hospitals in the first instance and then to other hospitals. The LIMs Business Case will be presented for approval to the Committee in December with the recommendation for ratification by the Board. Dr Jenkins supported the notion of delivering the financial plan this year vs a long-term financial plan, which is more subject to how the NHS is funded in the future. Mr Thickett informed the plans had been set on the national planning assumptions and funding settlements were based on Covid levels at the time of planning, reduced to 1% of the bed base, inflationary uplifts being circa of 4.5% In reality, the Trust is operating vastly different to the original national planning assumptions and funding settlements; the Trust is currently operating at 6%+ bed based from a Covid perspective, if based on current activity, the plan would be different and would have included retention of elective funds etc. The Efficiency and Productivity Programme (EPP) had reduced from the original planning levels, reported at £12.11m (4%) against the target which is a phenomenal achievement for efficiency delivery. The Board noted and received the reports.	
BoD 22/120	**People Committee Chair's Log** Mr Hudson presented the chair's log from the meeting held on 22 November 2022 which was noted and received. The Draft Trust People Plan which had been aligned with the pillars of the NHS People Plan, had been presented and approved by the Committee. Mrs Lavery was formally acknowledged for her hard work and support. The Board received and endorsed the plan. On behalf of the Board, Mrs McDonnell formally acknowledged and thanked Mr Hudson, Non-Executive Director for his support and dedication to the Trust during his term of office, wishing him well for the future.	
BoD 22/121	**Barnsley Facilities Services (BFS) Chair's Log** Mrs Ellis presented the chair's log from the BFS Board meetings held on 10 October and 21 November 2022 which was noted and received. One of the key highlights within the report was the BFS 5-year Celebration Day held in September 2022. A question was raised asking if the global supply issues are affecting or delaying treatment in any specialties. Mrs Ellis stated some of the issues had unfortunately	

	impacted treatment, however robust plans to mitigate the risks had been discussed with the CBU teams, to identify and source alternative medicines. One area of concern had been the provision of supplies for bowel preparation for Endoscopy procedures; due to the supply chain issues being global, Mr Kirton advised the Trust to work closely with the Integrated Care System (ICS) Management Teams to ensure patient safety was maintained.	
BoD 22/122	**Executive Team Report and Chair's Log** Dr Jenkins presented the chair's log from the ET meetings held throughout October and November 2022, advising no matters required escalation to the Board.	
BoD 22/123	**Audit Committee Chair's Log** Mr Mapstone presented the chair's log from the meeting held on 11 October 2022 which was noted and received. A query was raised regarding the risk management arrangements at CBU Level; asking what progress had been affected. The Clinical Director of CBU 3 had raised concerns regarding the effectiveness of risk management, and the Risk Management Group (RMG) had been asked to investigate. Mr Kirton stated concerns had been raised related to staffing challenges and due to the commencement of substantive staff, CBU 3 is reassured that mitigations are in place. A discussion was held at the Audit Committee as to whether the Board Assurance Framework/Corporate Risk Register (CRR) should be scrutinised at the RMG, and it was agreed that the group should retain oversight to provide consistency on risk scoring, escalating as appropriate.	
	PERFORMANCE	
BoD 22/124	**Integrated Performance Report (IPR)** Mrs Burnett presented the IPR for October 2022 following scrutiny at the recent Assurance Committees. The Trust continued to experience challenges with performance, noting the constitutional standards had not been met, despite benchmarking well against other providers. Ambulance handover times remained lower than other Trusts in South Yorkshire, with delays directly correlating to times of increased demand. As recovery continues, the Trust has zero patients waiting over two years, is within the top quartile of patients waiting over 52 weeks and is on track to achieve the national priority by March 2023. Following a query regarding cancer waiting times from GP referral to the commencement of treatment; Mrs Burnett informed 46 patients had waited longer than 62 days advising work continues with partners to reduce the numbers. The Board noted and received the report.	
BoD 22/125	**Trust Objectives 2022/23 Progress Report** Mr Kirton introduced the report providing an overview of progress made within quarter two following full scrutiny at the Assurance Committees. One of the main	

	highlights was the positive feedback received from staff and service users on the new Community Diagnostic Centre (CDC). One area of key concern is the number of formal complaints received relating to communication and failings in compassionate care. The Board was made aware robust actions are in place to mitigate this, including the "Always Events" to make improvements to the way patients are listened to and involved in decisions about their care. A partnership working group had been implemented with The Rotherham NHS Foundation Trust Steering Board. The paper provided the draft joint strategic statement for inclusion in the strategic documentation including the Trust Strategy 2022-27. The Board reviewed and endorsed the draft statement.	
BoD 22/126	**Maternity Services Board Measures Minimum Data Set** Mrs Collier-Hield presented the report providing an update on the Maternity Services Board Measures Minimum Data Set following full scrutiny at the Assurance Committee. To achieve Clinical Negligence Schemes for Trusts (CNST) compliance, additional documentation had been included in this month's report for Board oversight. Arising from the report the following key points were raised: • No new cases had been referred to Healthcare Safety Investigation Branch (HSIB), one report had been finalised with a meeting requested by the family. • Two incidents had been declared as Serious Incidents (SIs) at the Patient Safety Panel in October 2022; one in Obstetrics and one in Gynaecology. Two high-level reviews are ongoing and six incidents had been graded as moderate harm or above, duty of candour had been completed in all cases. • Progress has been made with training compliance, PROMPT compliance had been achieved. The study day has been redesigned and from January 2023, fetal monitoring training will be a separate full date, in addition to the elements of fetal monitoring covered in PROMPT training. As part of the CNST, all Paediatricans are required to be compliant with Newborn Life Support (NLS); all doctors had completed their training and achieved compliance. • Feedback had been received following the 360 Assurance review commissioned in July, about CNST safety actions 3, 6 and 9. The findings will be presented to the Audit Committee in January 2023. • Vacancy rate for Midwives reported at the end of October was 4.34 Band 5/6 wte (whole time equivalent) and 0.8 Band 7 wte. • Service user feedback response rate for friends and family test (FFT) remains low despite the addition of a QR code available on discharge packs. Work is ongoing to make improvements. • Whilst compliance safety action two should be complete, concerns had been raised regarding the IT systems due to the ability to extract information promptly. Following escalation to the ET, the digital process is currently being reviewed. The concerns have been escalated to the CRR. • As part of the Care Quality Commission (CQC) preparations, a peer visit had recently been held on 21 November 2022 noted to be a broadly positive report. • A review has been undertaken on the neonatal workforce in August 2022; an improvement plan has been implemented which is currently being worked through; there is a need to increase the number of nurses qualified in the	

specialty. As per CNST requirements, the Royal College of Obstetrics and Gynecology (RCOG) document "roles and responsibilities of the Consultant providing acute care in Obs and Gynae; an audit has been completed to ensure the Trust is compliant with the document. An action plan has been developed which will be monitored through Women's Business and Governance Meetings for assurance. The requirement is that the audit is presented to the Board for information.

- Improvements had been noted in the smoking rates at the time of delivery, above the national trajectory.

A query was raised asking how the Trust is assured that the HSIB actions are delivered, implemented and embedded within the Trust; Mrs Collier-Hield informed a deep-dive into the process had been completed earlier this week, advising all actions are documented through datix. The themes continue to be the same nationally and as a Trust, we are required to document the steps taken to date, particularly around CTG and escalation. The Trust continues to have quarterly meetings with HSIB.

With regard to the reduction in the Continuity of Carer (CoC) rates; the Board was informed three teams continue to provide care in the community and until safe staffing is in place in terms of headroom, the numbers will remain low. Although the targets had recently been removed from the NHS Long Term Plan, it is an ambition of the Trust to achieve this.

Staffing pressures remained to be experienced within the midwifery establishment, however the Board was assured that a range of initiatives are in place to ensure the Trust maintains safe staffing and safe patient care. To mitigate risks, several actions had been implemented including a local escalation policy and working closely with LMNS. On 3 November at the Strategic Focus Session, the Board supported the decisions made by the ET and Quality and Governance Committee to increase the headroom for midwives to fully reflect the last Birthrate plus report, sickness levels, and the training requirements as per Ockenden core competency framework.

On behalf of the Board, Mrs McDonnell thanked Mrs Collier-Hield for the comprehensive report which was noted and received.

East Kent Maternity Report: Mrs Collier-Hield presented the East Kent Maternity Report following publication in October 2022. As requested, all Maternity Services are requested to present and review the findings of the report to the Board, with the recommendation to support and approve the development of a Maternity Transformation Committee.

Although the East Kent Report does not list any recommendations, there are four suggested areas to focus on; to get better at identifying poorly performing units; giving care with compassion and kindness; team working with a common purpose and responding to challenges with honesty. An overview of the Trust's position relating to the actions was outlined within the paper.

The findings detailed within the report will be considered and included in the expansion of the current service development plan for Maternity Services at the Trust. The CBU 3 Senior Triumvirate is in support of undertaking cultural

	development across the service which will help engage staff with change and important work, as well as ensure all is delivered with kindness and compassion. The key next steps for the Trust is; to understand and triangulate, in greater depth, the experience of birthing people and their families; to improve teamwork and culture (continuous improvement) and ensure Maternity Voice Partnership (MVP) representation throughout the governance structure. To also note, discussions had been held at the Board Strategic Focus Session in November regarding maternity services, detailed discussions were held and considered, including the findings from the recently published East Kent report. The Board noted and received the report including the following recommendations: • Considered what the future internal governance processes need to look like to provide adequate assurance to Board about the maternity service in Barnsley. • Approved the development of a Maternity Transformation Committee, with an Executive level Chair to provide greater assurance at Board level. • Supported the sourcing of a bespoke teamwork package for staff in maternity services.	
	GOVERNANCE	
BoD 22/127	**Board Assurance Framework/Corporate Risk Register** Mr George introduced the BAF/CRR providing an update on the latest position. Both documents had recently been presented at the recent Executive Team meeting Assurance Committees **BAF:** The risks on the BAF had remained the same since the last presentation, noting that these had been mapped against the 2022/23 objectives. **CRR:** Two new risks had been added since the last presentation; Risk 2605 regarding anticipating evolving care needs to reduce Health Inequalities. Following a discussion at the Risk Management Group in August, it was agreed the likelihood is increased from possible to an extreme risk (scored 16); and Risk 2813 regarding the long-term gap in the maternity digital team impacting the data validity within the service, the likelihood increased from possible to an extreme risk (scored 15) Risk 2375 regarding the Covid-19 pandemic impact on Trust delivery of services had been de-escalated and scored at nine. The Board was made aware that the People Committee had recommended Risk 2773 regarding potential industrial action is increased from 12 to 20. This risk was presented to the ET on 30 November 2022, and in light of several potential industrial actions not materialised in terms of several Trade Unions not voting in favour, it was agreed no change would be made to the scoring. The risk is currently rated as a high risk (12) however in light of the recent announcement that nurses will take industrial action in December; it was agreed that the likelihood would be increased to almost certain. The Board noted and received the report.	

BoD 22/127	**Board Code of Conduct** Mr George introduced the Board Code of Conduct advising the purpose of the document was to provide clear guidance on the standards of conduct and behaviours expected by the Trust Board and non-voting attendee directors. In discussion, it was noted minor amendments are required to section 1.4 of the document and the addition of Associate Non-Executive Directors. Subject to minor amendments, the Board received and endorsed the Board Code of Conduct.	
	FOR INFORMATION	
BoD 22/128	**Chair's Report** Mrs McDonnell introduced the Chair's report which provided a summary of events, meetings, publications and decisions that require bringing to the attention of the Board. The Board noted and received the report.	
BoD 22/129	**Chief Executive Report** Dr Jenkins presented the Chief Executive's report providing information on several internal, regional and national matters that had occurred following the last Board meeting. In light of the current cost of living crisis and the risk of industrial action involving several staff groups, the Board was made aware that the Royal College of Nursing (RCN) had changed its approach to the planned industrial action for nursing colleagues. The strike is still taking place on the planned dates in December, however the RCN had picked out several large Trusts/Specialist Centres and it was confirmed Barnsley will not be affected. Trade Unions for the Ambulance Service had recently balloted to take industrial action. Although this will have a direct impact on Trust, assurance had been provided that emergency services will be maintained.	
BoD 22/130	**Intelligence Report** Ms Parkes presented the report providing an overview of NHS Choices reviews; reviews of strategic developments; and national and regional initiatives. The Board noted and received the report.	
BoD 22/131	**Barnsley Integrated Care Partnership Group (ICPG) Update** Mrs McDonnell advised no matters required escalation to the Board.	
BoD 22/132	**Acute Federation (AF) Update** Dr Jenkins provided a verbal regarding the AF. A development session for all Senior Leaders has been scheduled for Monday 5 December 2022, to explore development and progress to date. The Board was pleased to hear Cathy Hassell had been appointed as the Managing Director for the AF and will commence in post in January 2023.	

BoD 22/133	**Integrated Care Board (ICB) Update** Dr Jenkins advised work continued on the development of the newly defined strategy, due for completion on 20 December 2022. Once finalised, this will be presented to Board for information, along with a briefing circulated to the Council of Governors (CoG) **Integrated Care Board Chief Executive Report**: The report was included for information that was noted and received by the Board.	
BoD 22/134	**2021/22 Work Plan** The work plan, which sets out the work structure for the year ahead, was included for information purposes. The work plan will be amended in due course regarding the governance agenda items.	
BoD 22/135	**ANY OTHER BUSINESS** Mr George informed NHSE had requested for all Healthcare Services to assist with Module 3 of the Inquiry; which sets out 12 key areas for investigation. The official response requires submission by 19 December 2022, the Board was informed a paper will be presented to the ET on 14 December 2022 for ratification.	
BoD 22/	**Questions from Governors regarding the Business of the Meeting** On behalf of the CoG, Trust Members and Constituents, Mr Worsdale, as Lead Governor, raised the following questions/comments: • Staff Story: Mr Worsdale asked if any developments are taking place on the Paediatric Outpatients/Emergency Services. The Children's Department is a well-established service in the Trust, supported by Community Paediatric Clinics based at New Street, in Barnsley. The services are constantly reviewed to ensure improvements are made as necessary. • ReSPECT Training: Reference was made to the terminology used within the policy. The implementation of the policy is to be monitored by the Quality and Governance Committee, in particular the mandatory training requirements of staff. Mrs Murphy stated a vast amount of training and development is required by multi-professional groups, inpatient and outpatient services. Any concerns will be escalated and addressed by the Committee. • Vaccination rates: The vaccination rates for flu and Covid; reported at 35 and 42% were commented on; asking if the Trust is capturing the correct data as the numbers reported seemed a little low. Mr Ned stated current figures reported are 41.10% for flu and 46.2% for Covid. As the vaccinations are being offered outside the Trust, all staff are encouraged to confirm their vaccination status, which will be included within the figures to ensure that all staff are fully protected.	
BoD 22/	**Questions from the Public regarding the Business of the Meeting** Before the meeting, a statement had been published on the Trust's website inviting questions from members of the public. All submitted questions will be brought to the attention of the Chair and a decision will be made as to whether these will be raised in the meeting. On checking, no questions had been submitted.	
BoD 22/	**Date and Time of Next Meeting**	

	The next meeting of the Board of Directors Public Session will be held on Thursday 2 February 2023. In accordance with the Trust's Constitution and Standing Orders, it was resolved that members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted.	

1.5. Action Log

To Review

Presented by Sheena McDonnell

Board of Directors: Public Action Log 1 December 2022

Meeting Date	Agenda	Action	Assigned To	Progress / Notes	Due Date	Status
1 Dec 2022	Quality and Governance Committee Chair's Log: Annual Health and Safety Report	Mrs McDonnell thanked the team for the informative report, commenting it would be helpful to understand the impact/gaps, risks associated with the fire assessments not being in place and any training gaps. The Board agreed to delegate this to the Committee. Action: Mr Kirkton to delegate to Q&G.	Bob Kirton	Complete: Updates were given via the Health & Safety chairs log to the Quality and Governance Committee.	2 Feb 2023	Complete
1 Dec 2022	Quality and Governance Committee Chair's Log: ReSPECT Policy	ReSPECT policy to be presented at the Barnsley Place Meeting.	Bob Kirton	The RESPECT approach has already been discussed and agreed at a place level. It was raised at the place delivery group on 10/1 and it was felt the action plan was in hand.	2 Feb 2023	Complete
1 Dec 2022	Quality and Governance Committee Chair's Log:	Reference was made to the patient experience, engagement and insight report; Action: following discussion it was agreed the terminology describing the work relating to the "Always Events" was to be amended.	Kevin Clifford	Complete: amended as requested.	2 Feb 2023	Complete

1.6. Patient Story: verbal

To Note

Presented by Jackie Murphy

2. Assurance

2.1. Audit Committee Chair’s Log: 18 January

For Assurance

Presented by Nick Mapstone

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/2.1

SUBJECT:	**AUDIT COMMITTEE CHAIR'S LOG**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Nick Mapstone, Chair of the Audit Committee				
SPONSORED BY:	Nick Mapstone, Chair of the Audit Committee				
PRESENTED BY:	Nick Mapstone, Chair of the Audit Committee				

STRATEGIC CONTEXT

The Audit Committee advises the Board on the effectiveness of arrangements to manage organisational risks.

EXECUTIVE SUMMARY

The external audit of accounts is underway with clear agreed plans between the auditor and the finance team.

Seven internal audit reports have been issued since the last committee: two were advisory; three gave significant assurance opinions; and one (on the employment checks on agency staff) gave a limited assurance opinion.

The draft internal audit plan for 2023/24 was reviewed and will be finalised at the next Audit Committee.

One new possible fraud ('moonlighting') has been identified through our Freedom to Speak Up arrangements.

RECOMMENDATIONS

The Audit Committee recommends that the Board of Directors notes and takes assurance from the matters discussed.

Subject:	AUDIT COMMITTEE CHAIR'S LOG	Ref:	BoD: 23/02/02/2.1

CHAIR'S LOG: Key Issues and Assurance

Committee / Group	Date	Chair
Audit Committee	18 JANUARY 2023	Nick Mapstone

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2.1	**Standards of business conduct** The annual review of the policy document was approved subject to clarification of the definition of 'manager' and consideration as to whether the policy also applies to volunteers.	Board of Directors	To note
2.2	**Board assurance framework and corporate risk register** Continuing quality improvement of our risk management arrangements are underway with a stronger focus on actions and timescales. This will culminate in a review at a Board strategy session in March 2023, when the annual review of risk appetite will be undertaken.	Board of Directors	To note
3.2/4.5	**External audit of accounts and timetable** The external auditor (KPMG) is working closely with the finance team to plan the audit of accounts for 2022/23. KPMG is currently refreshing its understanding of systems and processes. This is particularly important as there is a new audit standard (ISA315R) that applies to all audited bodies. It puts increased emphasis on risk assessment during planning, with a focus on IT systems and automated controls that the finance team rely upon. The content of the plan is consistent with previous years. The risk profile remains the same as last year. KPMG has increased the materiality threshold percentage to 2.5 % of turnover	Board of Directors	To note

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
	compared with 2% in 2022/23. KPMG will report errors of more than £300,000, which is consistent with the prior year and in line with National Audit Office guidance. The value for money risk assessment is to be brought to the April Audit Committee. The annual reports and accounts timetable were agreed culminating in submission of the accounts to NHS England by 30th June 2023.		
3.3	**Internal audit progress report** The Committee noted satisfactory progress with the internal audit workplan. The following reports have been issued since the last Committee meeting: • Maternity Incentive Scheme (MIS) review: this audit was undertaken in an advisory capacity, a medium risk was raised following assessment of the Trust's evidence for MIS standards three, six and nine. • Review of HFMA Improving NHS financial sustainability checklist: non-opinion work, no significant issues raised. • Sustainability: significant assurance. • Business Planning and Covid Recovery: significant assurance. • Freedom to Speak Up: significant assurance. • Health and Wellbeing: significant assurance. • Agency Staffing (carried forward from the 2021/22 plan): limited assurance. Stage 2 of the Head of Internal Audit Opinion work programme is complete. One low risk finding has been raised, concerning shortcomings in the Board Assurance framework. The Trust's follow up rate for 2022/23 so far is: • first follow up rate: 73 per cent • overall follow up rate: 98 per cent	Board of Directors	To note

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
	There is currently one agreed internal audit action outstanding (a medium risk action from the Data Security and Protection Toolkit audit), which has been subject to extension at management's request.		
3.4	**Internal audit plan 2023/24** The Committee reviewed a summary of the topics identified for possible inclusion in the 2023/24 Internal Audit plan. These were proposed by members of the Executive Team, who's meeting the auditors attended on 4th January 2023. Internal audit will continue to refine the plan and a final plan will be presented to the April 2023 Audit Committee for approval. The plan will be 230 audit days.	Board of Directors	To note
3.6	**Local counter fraud service** The Committee noted that the Trust's arrangements comply with the requirements of the Counter Fraud Functional Standard as mandated by the NHS Counter Fraud Authority. The alleged charity fraud has progressed after many years. South Yorkshire police have referred the matter to the Crown Prosecution Service to determine whether there is a case to answer. One new fraud referral has been received. It concerns possible moonlighting while employed by the Trust. The matter was raised through our Freedom to Speak Up arrangements.	Board of Directors	To note
4.4	**Annual review of the effectiveness of internal audit** A positive review was received from both executive and non-executive directors.		

2.2. People Committee Chair’s Log: 24 January 2023 including:

- Gender Pay Gap Report 2022/Action Plan

For Assurance/Approval

Presented by Sue Ellis and Steve Ned

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/2.2

SUBJECT:	**PEOPLE COMMITTEE ASSURANCE REPORT**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Sue Ellis, Non-Executive Director / Committee Chair				
SPONSORED BY:	Sue Ellis, Non-Executive Director/ Committee Chair				
PRESENTED BY:	Sue Ellis, Non-Executive Director/ Committee Chair				

STRATEGIC CONTEXT

The People Committee is a committee of the Board responsible for oversight and scrutiny of the Trust's development and delivery of workforce, organisational development and cultural change strategies supporting the Trust's strategic priorities. Its purpose is to provide detailed scrutiny, to provide assurance and to raise concerns (if appropriate) to the Board of Directors in relation to matters within its remit.

EXECUTIVE SUMMARY

The Committee met on Tuesday 24 January 2023 chaired for the first time by Sue Ellis and we welcomed a new member, Gary Francis (both Non-Executive Directors.)

We considered the following items:

- Gender Pay Gap Report
- Workforce Insight Report
- Workforce Planning Review 2021/22
- Initial Embargoed Staff Survey Results from Picker
- New Freedom to speak up reflection and planning tool
- Q3 Review of People Objectives within the overall Trust Objectives
- Board Assurance Framework/Corporate Risk Register which include an update on maintaining patient safety during current industrial action by different NHS staff groups

For the purpose of assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached Log. The People Committee recommends the attached Gender Pay Gap report is approved by the Board of Directors, for publication on the Trust website by the end of March 2023.

Subject:	PEOPLE COMMITTEE ASSURANCE REPORT	Ref:	BoD: 23/02/02/2.2

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: People Committee	Date: 24th January 2023	Chair: Sue Ellis

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Gender Pay Gap Report	This document highlights Trust latest data set, which covers the 12-month period ending 31 March 2022. Overall, across our entire workforce our mean gender pay gap is 37%. This means that the average hourly pay rate for men is 37% higher than for women. This rate has increased from 36% at the last reporting period ending 31 March 2021. Our overall median gender pay gap is 24% - this means that the mid-point hourly rate for men is 24% higher than for women. A further analysis of the figures shows: For Medical and Dental staff, the mean gender pay gap is 18%. For all other staff who are not medical or dental (which is our largest workforce group), the mean gender pay gap is 6%. It was explained that this reflected age and service profiles as well as the societal picture and would continue to be slow moving as demographic changes in society took place. The action plan highlighted a number of initiatives in flexible/hybrid working; encouraging female consultants to be mentored and aspirational in clinical excellence awards, and talent management initiatives. In discussion, the committee pursued what percentage budget would be allocated to organisational development (OD); and	Board of Directors	Approval

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		'intersectionality' (meaning how the gender information relates to other potential forms of disadvantage which may be reflected in protected characteristics, such as race or disability). It was felt that following some minor amendments, the report should be brought forward to the February board for approval so that it can be placed on the public website of the Trust by end of March.		
2	Workforce insight report.	This regular report was presented by Victoria Racher, and there was further development shown on the SPC charts, providing richer information to the Committee, including benchmark information. Assurance was sought on how this information was being used within CBUs. It was agreed to request that this work gives a further focus on retention, and continues pending the provision of a national workforce plan.	Board of Directors	For approval
3	Workforce planning review report for 21/22.	This was a 12-month report showing the work of the workforce planning steering group and then a sample of detail of CBU level information in respect of individual roles. This is being used to feed into business planning and links to the five-year plan for the ICS. As this was the first time that such a report had been received, it was agreed to request an update in six months.	People Committee	For information
4	Staff Survey Results	Initial results at Trust level have been shared from the Picker information and can be shared internally but embargoed externally until the end of March 23, hence a full report will be brought to April Board.	People Committee	For Information
5	Freedom to Speak up Reflection and Planning Tool -	A revised assessment tool was shared for information. It was noted this was scheduled to go to the February Quality and Governance committee and would be brought to the Board	People Committee	For information

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		after a populated version had been seen at the March People committee.		
6	Progress on Trust objectives	The Quarter three report was received and noted that progress continues to be made on the 'people pillar' of our strategic plan.	Board of Directors	For discussion
7	Board Assurance Framework and Corporate Risk Register	The items and risks ascribed to the committee were discussed. It was noted there was a new risk related to vacancies in haematology consultants in post, and mitigation arrangements. Following positive feedback through a number of sources, it was agreed to review for next time whether the risk on staff health and well-being could be re-scored. The meeting was updated on current NHS industrial action and the risks and mitigations to patient safety. It was noted that significant work had been undertaken by both Trust leaders and trade union representatives to work in partnership to ensure patient safety is preserved at Barnsley hospital, and it was reflected that positive local relationships remain with representatives of the RCN and other trade unions.	Board of Directors	For assurance

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REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/2.2i

SUBJECT:	**GENDER PAY GAP REPORT 2022/ACTION PLAN**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	√		*Assurance*	✓
	For review			*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Sharon Hargreaves, Workforce Planning & Information Manager Emma Lavery, Deputy Director of Workforce				
SPONSORED BY:	Steven Ned, Director of Workforce				
PRESENTED BY:	Steven Ned, Director of Workforce				

STRATEGIC CONTEXT

Best for People: We will make our Trust the best place to work by ensuring a caring, supportive, fair and equitable culture for all.

EXECUTIVE SUMMARY

All UK employers have a legal requirement to publish their gender pay data on an annual basis.

The report for Barnsley Hospital NHS Foundation Trust reviews the latest data set, which covers the 12-month period ending 31 March 2022.

Overall, across our entire workforce our mean gender pay gap is 37%. This means that the average hourly pay rate for men is 37% higher than for women. This rate has increased from 36% at the last reporting period ending 31 March 2021. Our overall median gender pay gap is 24% - this means that the mid-point hourly rate for men is 24% higher than for women.

A further analysis of the figures shows: For Medical and Dental staff, the mean gender pay gap is 18%. For all other staff who are not medical or dental (which is our largest workforce group), the mean gender pay gap is 6%.

The report provides further analysis of the data, explanatory narrative and our future intentions and actions planned to help close the gender pay gap, including:

- The development of a high-level talent management approach as part of the Organisational Development (OD) Strategy by end of March 2023.
- The expansion of our internal Coaching and Mentoring capability as part of the OD Strategy.
- The approval and launch of a new hybrid working and home working policy and toolkit.
- The setting up of a Trust wide flexible working group to review our approach and staff access to flexible working and fair rostering.

- To build upon the recent launch of our new working carers support group and increase engagement and membership.
- To offer a mentoring and buddying scheme for female and male Consultants to encourage and support them with their Clinical Excellence Awards applications as the scheme has recently changed.

RECOMMENDATION

The Board of Directors is asked to approve the report and action plan for external publication on the designated government website and the Trust's website by the reporting deadline of 30 March 2023.

Barnsley Hospital NHS Foundation Trust

Gender Pay Gap Report 2022

Executive Summary

All UK employers have a legal requirement to publish their gender pay data on an annual basis.

The gender pay gap calculation is based on the average hourly rate paid to men and women. This calculation makes use of two types of averages; a mean average and a median average. In simple terms, the mean is the average hourly rate and the median is the mid-point hourly rate for men and for women in the workforce.

The mean figure is the figure most commonly used.

The report for Barnsley Hospital NHS Foundation Trust reviews the latest data set, which covers the 12 month period ending 31 March 2022.

Our Overall results:

Overall, across our entire workforce our mean gender pay gap is 37%. This means that the average hourly pay rate for men is 37% higher than for women. This rate has increased from 36% at the last reporting period ending 31 March 2021.

Our overall median gender pay gap is 24% - this means that the mid-point hourly rate for men is 24% higher than for women.

However, this overall figure represents the combined data for our Medical and Dental staff group and all other staff groups.

A further analysis of the figures shows:

- For Medical and Dental staff, the mean gender pay gap is 18%
- For all other staff who are not medical or dental (which is our largest workforce group), the mean gender pay gap is 6%. See table 2 below.

Our proportion of male and female staff should be taken into account when looking at our gender pay gap, as should the age range of our male and female workforce, as members of staff who have enjoyed long careers in the NHS can often be higher up the pay point scales than those who are just starting their careers.

In Barnsley, whilst we have a higher proportion of female staff in our workforce, we also have a significant proportion of our male workforce who are now at the point in their careers where they are senior medical staff and therefore are higher up the pay grades than some more junior members of staff. This is reflected in our overall gender pay gap and, as a trust, we recognise that this is a generational and societal issue. We know that an increasing number of women are choosing medicine as a career and our figures this year show that we have more female foundation doctors than male. 32 female doctors (54%) and 27 male doctors (46%).

Over the last 7 years we have seen a gradual increase in the number of female consultants working at the Trust and as a result, our consultant profile gender gap is reducing as shown below:

Table 1

as at 31 March	Female	% Female	Male	% Male	Total
2022	60	34.09%	116	65.91%	176
2021	68	32.54%	141	67.46%	209
2020	62	31.47%	135	68.53%	197
2019	56	28.57%	140	71.43%	196
2018	48	28.40%	121	71.60%	169
2017	45	28.48%	113	71.52%	158
2016	41	28.28%	104	71.72%	145
2015	41	28.08%	105	71.92%	146

For Medical and Dental staff, the mean gender pay gap for the last reporting period ending 31 March 2022 has increased to 18% from 17% in the previous reporting period ending 31 March 2021.

Table 2

Gender	Non-medical & dental staff mean hourly rate £	Medical & Dental staff mean hourly rate £	Overall workforce mean hourly rate £
Male	£16.47	£44.29	26.20
Female	£15.45	£36.23	16.52
Mean Pay Gap %	6.19%	18.20%	36.95%

Table 3

Gender	Non -Medical & dental staff headcount	Medical & dental staff headcount	Total headcount
Male	424	228	652
Female	2777	151	2928
Total	3201	379	3580*

* excludes BFS and counts relevant employees only.

The proportion of male and female employees in the lowest pay quartile is 87% female and 13% male, compared to the proportion of male and female employees in the

highest pay quartile which is 66% female and 34% male. (The quartile information is created by sorting all employees by their hourly rate of pay and then splitting the list into 4 equal parts to create 4 pay quartiles).

The gender pay gap data we report also includes bonus payments. The consultants' clinical excellence awards (CEAs) are included in the bonus pay calculation. Following publication of previous results, we have undertaken proactive communications and publicity, and training support has been offered to female and male consultants on how to apply for CEAs.

Our mean gender bonus pay gap has increased slightly since the previous reporting period to 71%. Our median gender bonus pay gap has also increased since the previous reporting period from 88% to 96%.

Our future intentions:

As a Trust we are committed to supporting the career progression and ensuring equal opportunities for women and men within our workforce. A high-level Talent Management approach will be included as part of the Organisational Development (OD) Strategy by end of March 2023. It will highlight what more we can do to develop career progression and to effectively succession plan within the Trust, including how we identify and develop Talent at an organisational level. We are keeping abreast of wider NHS developments including the potential for career and talent management at regional level. Already, we invest in Talent Development programmes and in 2022 we extended our offering by including an intake programme for Bands 2-3, to complement existing intakes for Bands 4-6 and Bands 7+. Of the 10 successful applicants for the programmes, 100% are female.

We are also planning to expand our internal Coaching and Mentoring capability as part of the OD strategy, which will provide more support for the career progression of our Talent. With regards to Leadership, a Compassionate and Inclusive Leadership module was introduced to the trust in 2022 and uptake has been healthy – this is an area we wish to develop further as part of our investment in Leadership Development, which will include clearer signposting as to the Leadership Development support available. A further area of focus will be to align the right resources and capacity for Organisational Development to take forward the work planned. In future years we will also look at issues of intersectionality in respect of pay i.e. looking at the wider aspects of potential pay disparity, for example, race and disability pay gaps.

We have a range of family friendly policies, supporting childcare and other carer commitments, flexible working, fair rostering and leave provision. We have published a number of toolkits to help managers in applying these policies for our staff and have held a series of policy training sessions for managers. As the COVID-19 pandemic has taught us, it is possible for a number of roles to embrace a new type of flexible working known as hybrid working. Consultation has commenced on a new hybrid working and home working policy and toolkit, which will help in embedding flexibility in where and how people work going forward.

We are setting up a new working group in January 2023, focusing initially on supporting our nursing and midwifery colleagues, to review our approach and access

to flexible working and fair rostering, learning from best practice areas and national toolkits to champion, showcase and pilot case studies to the Trust on what is possible as we work towards creating a flexible working culture.

In 2022 we have launched our carers support group to raise awareness and increase recognition and support of staff who are carers, to identify what issues they face, leading to improved engagement and retention.

We welcome this report and the findings. The data has given us the opportunity to understand what else we can do to further reduce our gender pay gap. Ultimately, our aim is to ensure that men and women have equal opportunities in the workforce at all levels.

Gender Pay Gap Detailed Results

Our gender pay gap results (based on the hourly pay rates our employees received on 31 March 2022) are as follows:

- Our mean gender pay gap is 37%
- Our median gender pay gap is 24%
- Our mean bonus gender pay gap is 71%
- Our median bonus gender pay gap is 96%
- Our proportion of males receiving a bonus payment is 9%
- Our proportion of females receiving a bonus payment is 2%

Our proportion of males and females in each quartile pay band is;

Quartile	Female %	Male %
1	87.26%	12.74%
2	86.03	13.97
3	88.27	11.73%
4	65.59%	34.41%

The reasons behind our gender pay gap -

- The mean and median gender pay gap can be explained by the observation that while men make up only 18% of the workforce, there is a disproportionate number of males, 34% in the highest paid quartile.
- The Trust's mean gender pay gap is 37% in favour of men (women earn 37% less than men) compared to the national average of 14.9% in favour of men (a decrease from 15.1% in 2021 and 17.4% in 2019) [source: Annual Survey of Hours and Earnings, Office for National Statistics, 2022].

- There is no significant mean gender pay gap in the Non-medical & Dental staff groups (6%). There is a mean gender pay gap of 18% in the Medical & Dental staff group.

- The table below shows Agenda for Change pay bands 2 to 8b split by gender and average hourly rate:

Band	Female	Male	Average hourly rate female	Average hourly rate male
2	565	72	10.77	10.44
3	468	62	11.40	11.52
4	189	32	12.29	11.86
5	645	86	16.14	15.36
6	504	65	18.67	17.94
7	284	54	21.75	21.64
8a	77	20	24.96	25.38
8b	16	11	28.74	29.48

- The female average hourly rate is higher in all AfC pay bands except band 3, 8a and 8b, where the male average hourly rate is higher by 0.12p,0.42p and 0.74p.

- As at 31 March 2022 there were 12 female (50%) and 12 male (50%) employees on Local Senior Manager or Exec/Non-Exec Director pay scales, compared to 47% of very senior manager roles in the NHS held by women (NHS Employers data from NHS Digital workforce statistics 2018).

- There were 60 female (34%) and 116 male (66%) M&D consultants, compared to 63% of consultants who are men and 37% of consultants who are women in the NHS (NHS Employers data from the NHS Digital workforce statistics 2018). There were 32 female (54%) and 27 male (46%) foundation doctors.

- The gender split by age shows the majority of female doctors are young (of those aged 21 – 40, 50% are female compared to 50% male) and the majority of male doctors are older (of those aged 41 and over, 70% are male and 30% are female).

  In the reporting period, there were 78 medical staff (22 women and 56 men) who received Clinical Excellence Awards and Discretionary Points Awards which accounts for 74% of all bonuses awarded. There were 27 staff (24 women and 3 men) who received Long Service Awards in the form of monetary awards which accounts for 26% of all bonuses awarded. 3% of the total number of 'relevant employees' received bonus pay.

Table below shows number of Clinical Excellence Awards received:

Year	Female	Male	Total Received CEA
2019	23	58	81
2020	23	51	74
2021	46	91	137
2022	22	56	78

- Eligible consultants higher in 2021 as the funds were distributed equally amongst all eligible consultants instead of running an award ceremony.

Reducing our gender pay gap:

- **Female consultants applying for Clinical Excellence Awards (CEAs)**

Following the publication of previous gender pay gap results, further analysis was undertaken on the gender split of eligible consultants who applied and were successful in receiving CEAs over the last 5 years. On average a slightly lower proportion of female consultants applied (23% compared to 27% males). Consultants that applied had equal chance of receiving the award regardless of gender and the panel's gender split was proportionate.

Three years ago, proactive communications, publicity and training support was offered to female and male consultants on how to apply for CEAs. The data has been refreshed to include the last financial year awarded and over the last 5 years on average the gender gap of CEA applicants has slightly reduced to 23% female consultants applied compared to 25% males. Of those who applied on average, 59% female consultants were successful compared to 66% males.

However, the increase in female applicants in 2016/17 (29% compared to 26% male applicants) has not been sustained. In 2017/18 there were 24% female and 24% male applicants. Of those who applied, 67% women and 90% men were successful in their applications.

Due to the ongoing Covid 19 pandemic the awards for the 2020, 2021 and 2022 financial years have been equally distributed to all eligible consultants.

In preparation for the 2023 round the Trust will look to offer a mentoring and buddying scheme for female and male consultants to encourage and support them with their CEA applications as the scheme has changed. Consultants both male and female will be encouraged to be part of the working group to develop the new process and offer a mentoring scheme from individuals who have previously been successful in their applications.

- **Supporting flexible working and ensuring fair rostering**

93% of part time workers are female, compared to 74% of full time workers who are female;

	Female	Male	% Female working	% Male working
part time	1307	92	36.51%	2.57%
full time	1621	560	45.28%	15.64%

The gender pay gap results show that men's average hourly rate is higher for both part time and full time workers;

	Female	Male	Average hourly rate female	Average hourly rate male
part time	1307	92	16.45	25.42
full time	1621	560	16.58	26.33

As at 31 March 2022, there were 115 women on maternity leave and no women on adoption leave. There were no men on adoption or maternity support (paternity leave). There were no women or men on shared parental leave.

These results tell us that the provision and fair access to part time and flexible working opportunities are important to support the needs and retention of our workforce.

30% of respondents to the 2021 staff survey were registered nurses and midwives. Only 50% of respondents agreed to the statement 'my organisation is committed to helping me balance my work and home life' and 59% were satisfied with opportunities for flexible working patterns. It is one of the key drivers to improve our staff retention and wellbeing, and also help address our gender pay gap, as reflected in our gender pay gap action plan.

We have completed a review of our flexible working policy to ensure access is offered from the first day of employment. We have updated the rostering policy and fair rostering top tips at a series of drop in training sessions for managers. A working group has now been established to focus on the next steps which are to support our managers and colleagues to be able to give access to flexible working arrangements which is fairly and consistently applied across the organisation. Taking learning from best practice areas and national toolkits to champion, showcase and pilot case studies to the Trust on what is possible as we work towards creating and embedding a flexible working culture. Improved monitoring and reporting of flexible working arrangements will help measure our success.

As the COVID-19 pandemic has taught us, it is possible for a number of roles to embrace a new type of flexible working known as hybrid working. Consultation has commenced on a new hybrid working and home working policy and toolkit, which will help in embedding flexibility in where and how people work going forward.

- **Developing and refining our approach to talent management and succession planning**

A high level Talent Management approach will be included as part of the OD Strategy by end of March 2023. It will highlight what more we can do to develop career progression and to effectively succession plan within the Trust, including how we identify and develop Talent at an organisational level. We are keeping abreast of wider NHS developments including the potential for career and talent management at regional level. Already, we invest in Talent Development programmes and in 2022 we extended our offering by including an intake programme for Bands 2-3, to complement existing intakes for Bands 4-6 and Bands 7+. Of the 10 successful applicants for the programmes, 100% are female. We are also planning to expand our internal Coaching and Mentoring capability as part of the OD strategy, which will provide more support for the career progression of our Talent. With regards to Leadership, a Compassionate and Inclusive Leadership module was introduced to the trust in 2022 and uptake has been healthy – this is an area we wish to develop further as part of our investment in Leadership Development, which will include clearer signposting as to the Leadership Development support available. A further area of focus will be to align the right resources and capacity for Organisational Development to take forward the work planned.

Sharing our gender pay gap with our employees

It is important to share and explain our gender pay gap and our action plan to reduce the gap with our employees, trade union representatives and managers. In particular to be clear about the difference between gender pay and equal pay. The solutions to equal pay and gender pay are different. Closing the gender pay gap is a broader societal as well as organisational issue. Though we have a gender pay gap due to our disproportionate representation of men and women within the workforce (as reflected across the NHS), we are confident that we pay fairly in accordance with the nationally recognised Agenda for Change and Medical & Dental pay structures and our locally recognised Senior Manager and Director pay structures.

It is proposed to share the information with the People & Engagement Group, Joint Partnership Forum and the Joint Local Negotiating Committee and explain what the data shows. Also, to agree an internal communications message for distribution and briefing all staff.

The difference between gender pay and equal pay

It is important to be clear about the difference between gender pay and equal pay. The solutions to equal pay and gender pay are different. Closing the gender pay gap is a broader societal as well as organisational issue.

Though we have a gender pay gap due to our disproportionate representation of men and women within the workforce (as reflected across the NHS), we are confident that we pay fairly in accordance with the nationally recognised Agenda for Change and Medical & Dental pay structures and our locally recognised Senior Manager and Director pay structures.

As part of the introduction of the Agenda for Change modernised NHS pay structure in 2004 was the development of the NHS Job Evaluation Scheme as a means of determining pay bands for posts. The key feature in both the design and implementation of this scheme was to ensure equal pay for work of equal value. The scheme has been tested legally and has been found to be equal pay compliant. The process involves use of job descriptions and person specifications which accurately reflect the demands of the job. Jobs are then locally matched to national benchmark profiles or locally evaluated and consistency checked by trained matching panel members and job evaluators consisting of management and staff side representatives working in partnership. The jobs are scored against a sufficiently large number of weighted factors (16) to ensure that all significant job features have been measured fairly. This includes specific factors to ensure that features of predominantly female jobs are fairly measured, for example communication and relationship skills, physical skills, responsibilities for patients and emotional effort. Scoring and weighting has been designed in accordance with a set of gender neutral principles, rather than with the aim of achieving a particular outcome, for example all responsibility factors are equally weighted to avoid one form of responsibility been viewed as more important than others.

The NHS Staff Council job evaluation handbook provides guidance and advice on the NHS job evaluation scheme, which has been used to shape the Trust's locally agreed job evaluation policy and procedure.

Conclusion

The People Committee received the report at its meeting held on 24 January 2023 and supported the submission of the paper to the Trust Board meeting to be held on 2 February 2023, to request approval of the report and action plan for external publication on the designated government website and the Trust's website by **the reporting deadline of 30 March 2023.**

Appendix 1

Gender Pay Gap Data

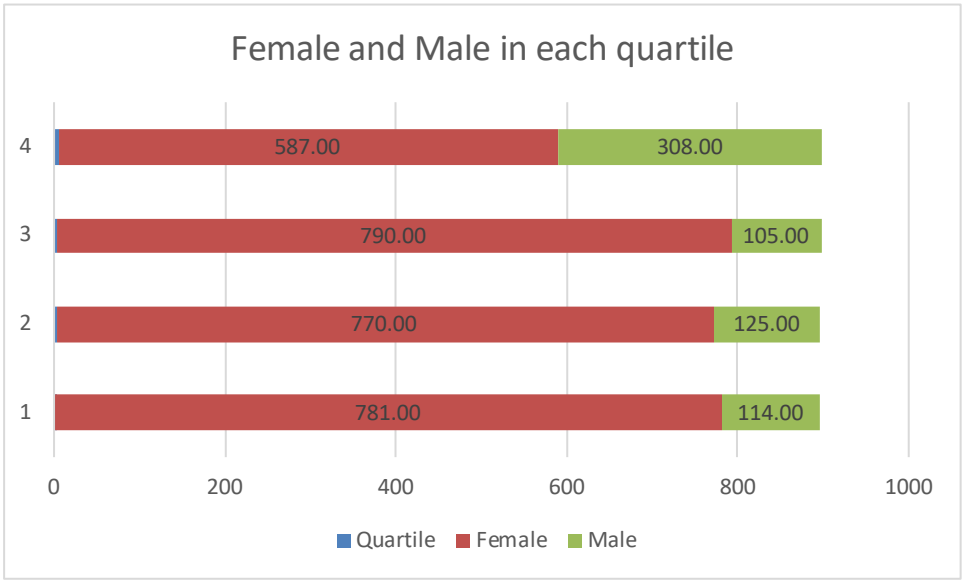
Data from ESR as at 31 March 2022

Data based on 3580 Full Pay Relevant Employees.

A “Full Pay Relevant Employee” is any employee who is employed on the snapshot date (31 March 2022) and who is paid their usual full basic pay during the relevant pay period (1 – 31 March 2022).

Proportions of male and female employees in each pay quartile based on Ordinary Pay

Quartile	Female	Male	Female %	Male %
1	781.00	114.00	87.26%	12.74%
2	770.00	125.00	86.03	13.97
3	790.00	105.00	88.27	11.73%
4	587.00	308.00	65.59%	34.41%



Key Points:

- Ordinary pay includes basic pay, allowances, pay for leave, shift premium pay and on call pay.

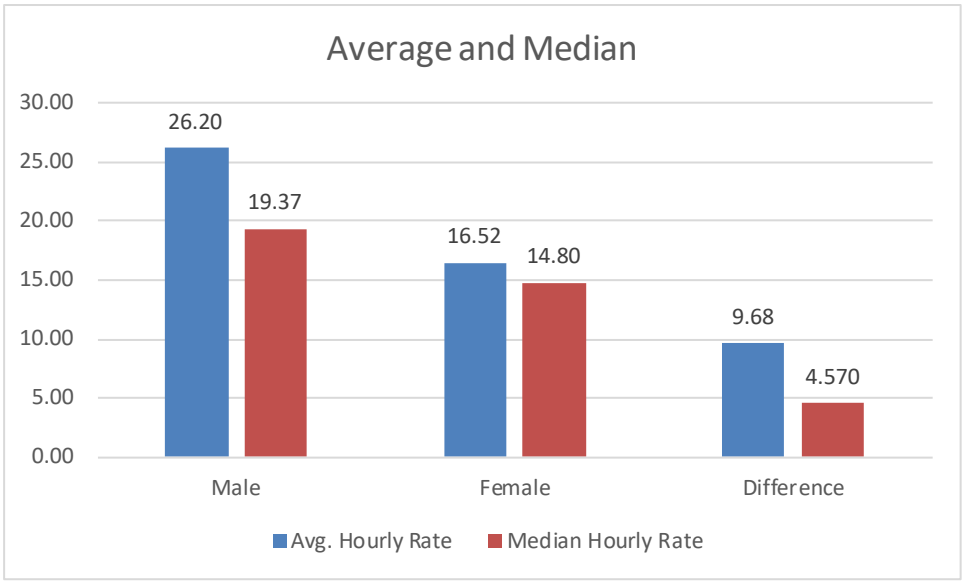
- In order to create the quartile information all staff are sorted by their hourly rate of pay this list is then split into 4 equal parts (where possible).

- To calculate the hourly pay, the employee’s bonus payments (this includes clinical excellence awards, discretionary points awards and long service awards) are added to their ordinary pay and this is divided by the employee’s number of working hours.

- To calculate the number of working hours the on call units worked and basic hours are added together. This inflates the units worked which then lowers the hourly pay. For example 162.95 basic hours plus 48.00 on call weekend plus 121.00 on call weekday equals 331.95 units worked divided by the pay value £4301.41 equals an hourly pay of £12.96

- Elements of salary sacrifice have been removed

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	26.20	19.37
Female	16.52	14.80
Difference	9.68	4.570
Pay Gap %	36.95%	23.59%



Key Points:
• The mean hourly and the median hourly rate of pay is calculated from a specific pay period, in this case it is 1st of March to 31st March 2022. The hourly rate is calculated for each employee based on 'ordinary pay' which includes basic pay, allowances and shift premium pay. The median rate is calculated by selecting the average hourly rate at the mid-point for each gender group.

• The percentage variance for the mean hourly rate of pay is 9.68%. This calculation is based on the mean hourly rate of 2928 female staff compared to 652 male staff; because the average is calculated over different numbers of staff (there are over 4 times more female staff), some variance is to be expected.

•The data includes both staff on Agenda for Change and staff on non-Agenda for Change terms and conditions (see sections below for a breakdown of Medical & Dental Staff and Non-Medical & Dental Staff gender pay gap results).
This data excludes Barnsley Facility Services as they have a separate payroll and as they are a Private company they have a different snapshot date of 5th April.

Within each Quartile by Gender working Part time or Full time :

Quartile 1					
	Female	Male	% Female Working	% Male Working	Total
Part time	374	23	94.21%	5.79%	397
Full Time	407	91	81.73%	18.27%	498
Quartile 2					
	Female	Male	% Female Working	% Male Working	Total
Part time	294	16	94.84%	5.16%	310
Full Time	476	109	81.37%	18.63%	585
Quartile 3					
	Female	Male	% Female Working	% Male Working	Total
Part time	393	16	96.09%	3.91%	409
Full Time	397	89	81.69%	18.31%	486
Quartile 4					
	Female	Male	% Female Working	% Male Working	Total
Part time	246	37	86.93%	13.07%	283
Full Time	341	271	55.72%	44.28%	612

Key Points:
Proportion of part time workers who are female is consistent throughout pay quartiles 1 to 3 (45 – 96%). There are less full time workers who are female in quartile 4 (56%) compared to the lower pay quartiles.

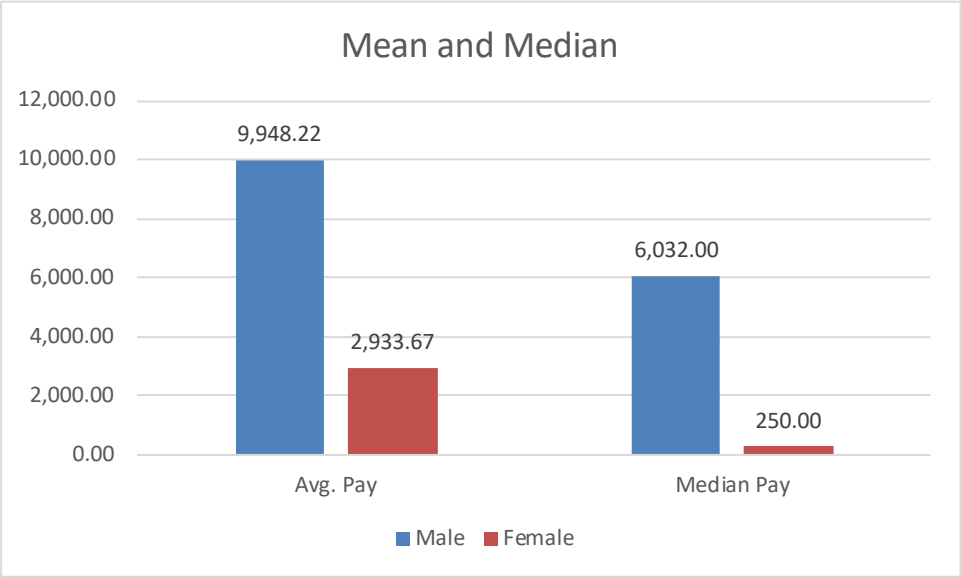
Mean and Median Gender Bonus Pay Gap Results

Data based on **3580** Relevant Employees.

"Relevant Employees" are all employees who are employed on the snapshot date (31 March 2022) and this term includes full-pay relevant employees and also other employees employed on the snapshot date but on less than full pay because of leave (which has reduced pay).

Gender	Avg. Pay	Median Pay
Male	9,948.22	6,032.00
Female	2,933.67	250.00
Difference	7,014.55	5,782.00
Pay Gap %	70.51%	95.86%

The bonus period is a twelve month period that ends on the snapshot date. And will always be the preceding twelve months.



Proportion of male and female employees who received bonus pay

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	46	2928	1.57%
Male	59	652	9.05%

Key Points:

- The gender pay gap calculations make use of two types of averages; a mean average and a median average.

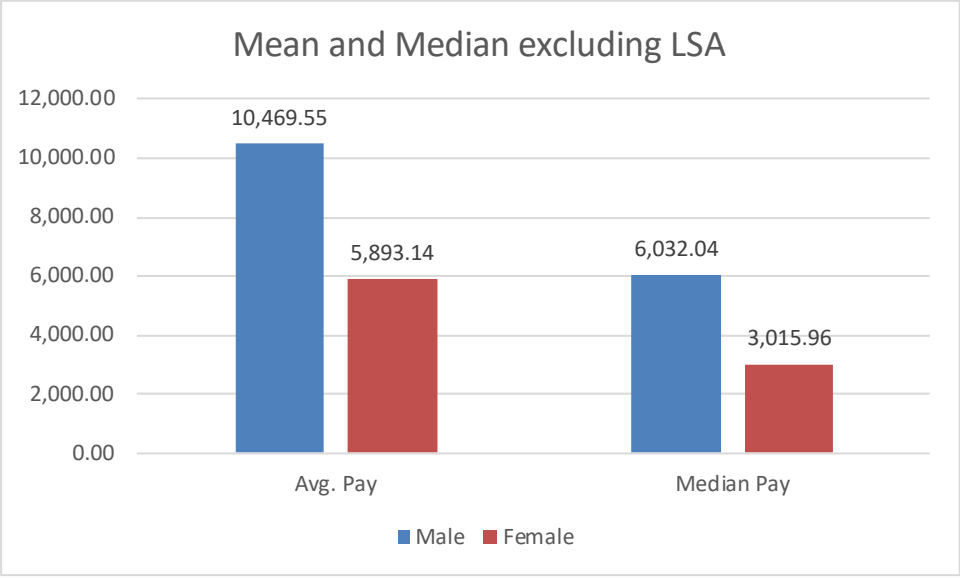
- Mean averages give a good overall indication of the gender pay gap, but very large or small pay rates or bonuses can 'dominate' and distort the answer. For example, mean averages can be useful where most employees in an organisation receive a bonus but could be less useful in an organisation where the vast majority of bonus pay is received by a small number of employees (as is the case here).

- Median averages are useful to indicate what the 'typical' situation is i.e. in the middle of an organisation and are not distorted by very large or small pay rates

or bonuses. However, this means that not all gender pay gap issues will be picked up.

- The bonus pay criteria includes Clinical Excellence Awards (CEAs) and Discretionary Points Awards paid to 46 female and 59 male medical staff during 1st April 2021 and 31st March 2022. It also includes Long Service Awards (monetary awards in the form of shopping vouchers) given in 2022 for service gained in 2021. 24 Females and 3 Males received a Long Service Award (LSA). Therefore the number of employees who received a bonus payment is small, the value and type of bonus payments received is varied with more men receiving the higher value CEAs and more women receiving the lower value LSAs and this has distorted the figure.

- The Clinical Excellence Awards payments have been included in the bonus pay calculation (and the average hourly rate calculation) because the payments are subject to eligible applicants demonstrating that they are performing 'over and above' the standards expected in their role. Also in accordance with the Trust's Local Employer Based Awards (Clinical Excellence Awards) Policy the awards are subject to application for renewal every 5 years.
- This calculation expresses the number of staff receiving bonus pay as a percentage of the total number of staff in each gender group.



Appendix 2

Non - Medical and Dental Gender Pay Gap Results

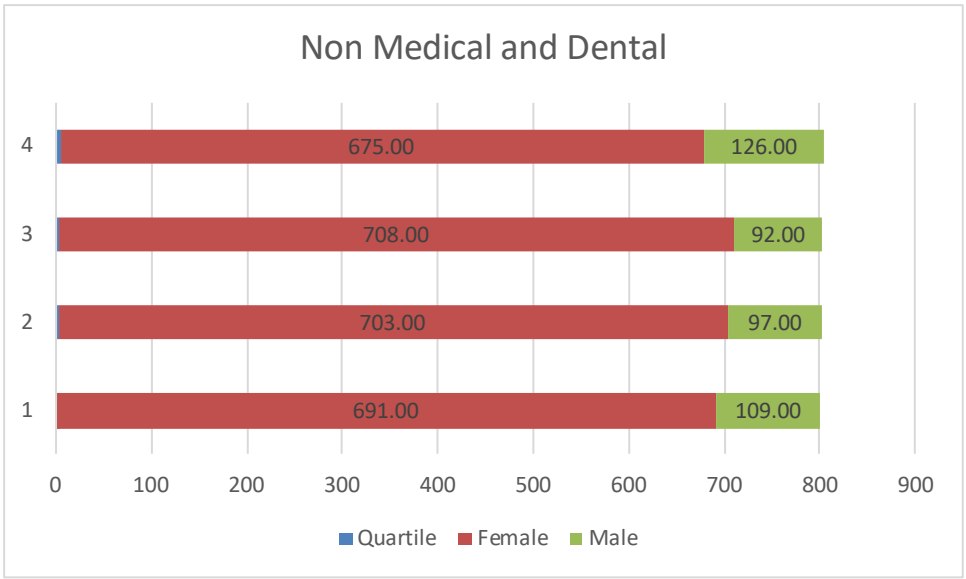
Data from ESR as at 31 March 2022

Data based on 3201 Full Pay Relevant Employees.

A “Full Pay Relevant Employee” is any employee who is employed on the snapshot date (31 March 2022) and who is paid their usual full basic pay during the relevant pay period (1 – 31 March 2022).

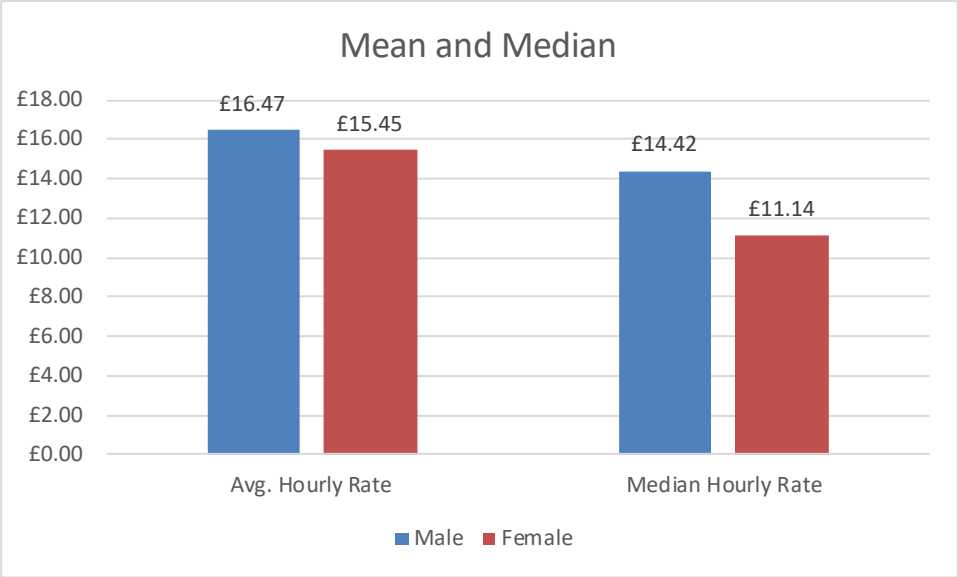
Proportions of male and female employees in each pay quartile based on ordinary pay

Quartile	Female	Male	Female %	Male %
1	691.00	109.00	86.38%	13.63%
2	703.00	97.00	87.88%	12.13%
3	708.00	92.00	88.50%	11.50%
4	675.00	126.00	84.27%	15.73%



Mean and Medial Gender Pay Gap Results

Gender	Avg. Hourly	Median
Male	£16.47	£14.42
Female	£15.45	£11.14
Difference	£1.02	£3.28
Pay Gap %	6.19%	22.75%



Key Points:

• The percentage variance for the mean hourly rate of pay is 6.19%. This calculation is based on the average hourly rate of 2777 female staff compared to 424 male staff; because the average is calculated over different numbers of staff, some variance is to be expected.

Appendix 3

Medical and Dental Gender Pay Gap Results

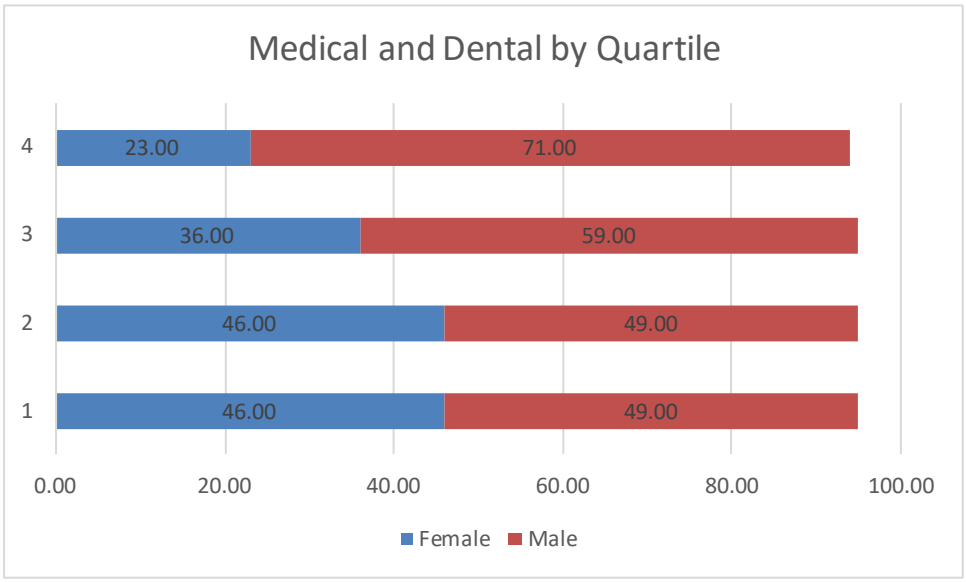
Data from ESR as at 31 March 2022

Data based on 379 Full Pay Relevant Employees.

A “Full Pay Relevant Employee” is any employee who is employed on the snapshot date (31 March 2022) and who is paid their usual full basic pay during the relevant pay period (1 – 31 March 2022).

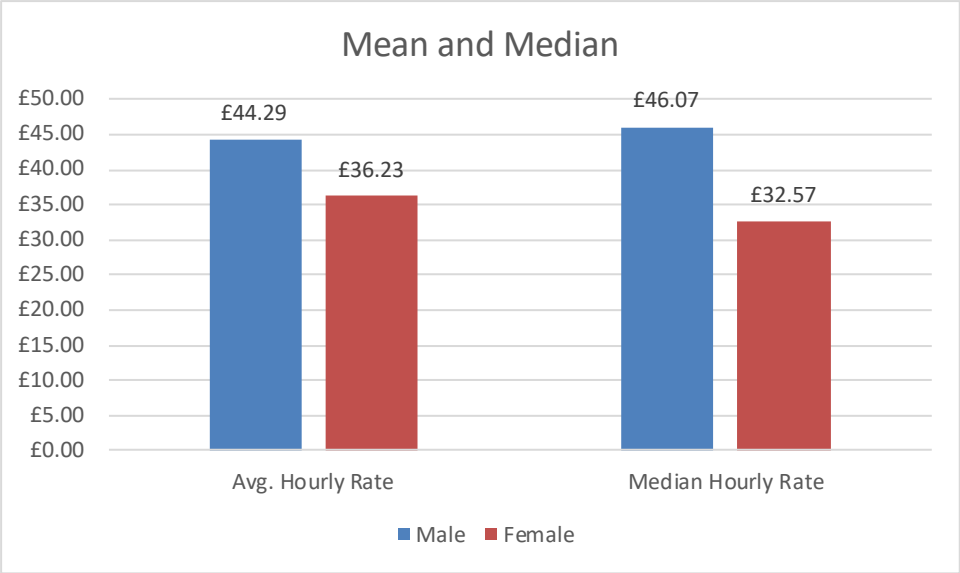
Proportions of male and female employees in each pay quartile based on Ordinary Pay

Quartile	Female	Male	Female %	Male %
1	46.00	49.00	48.42%	51.58%
2	46.00	49.00	48.42%	51.58%
3	36.00	59.00	37.89%	62.11%
4	23.00	71.00	24.47%	75.53%



Mean and Median Gender Pay Gap Results

Gender	Avg. Hourly	Median
Male	£44.29	£46.07
Female	£36.23	£32.57
Difference	£8.06	£13.50
Pay Gap %	18.20%	29.30%



Key Points:

• The percentage variance for the mean hourly rate of pay is 18%. This calculation is based on the average hourly rate of 151 female staff compared to 228 male staff; because the average is calculated over different numbers of staff, some variance is to be expected.

Gender Pay Gap Report Action Plan 2022-2023 to 2023-2024

Aims/ Targets/ Objectives	How this will be achieved	What expected outcome will be	What evidence will support this	Who will lead this	Timescales this will be achieved within	Where this will be reported/ monitored to - ie Committee/ Group	Timescale	Progress Update January 2023
To reduce the Trust's gender pay gap	Review the trust's policies for offering flexible working and fair rostering to ensure access and provision is available for all pay grades	Equal and fair access and provision of part time, job share, flexible and remote working arrangements.	Revised flexible working policy Revised rostering policy	HRBP E-Rostering Lead Nurse	Before next GPG reporting period	People Committee	Completed	We have completed the review and launched our revised flexible working policy in line with updated AfC T&Cs, to ensure access is available from the first day of employment. We have updated and launched our revised rostering policy and fair rostering top tips.
	Consider feasibility of introducing/piloting team-based rostering and assess merits of switching off current auto-rostering	Equal and fair access and provision of part time, job share, flexible and remote working	Effective Team-based rostered areas	Deputy Director of Workforce Senior Nurse Team E-Rostering	Before next GPG reporting period	People Committee	June 2023	A working group has been established in January 2023 focusing initially on supporting our

	functionality within healthroster system from perspective of improving flexibility and fairness for all	arrangements.		Lead Nurse				nursing & midwifery managers and colleagues to be able to offer flexible working and fair rostering which is fairly and consistently applied
	Develop practical support guides for managers and staff to proactively have conversations and manage requests for flexible working.	Equal and fair access and provision of part time, job share, flexible and remote working arrangements.	Flexible working Toolkit	HRBP	Before next GPG reporting period	People Committee	July 2023	The flexible working group will develop support guides and toolkits for managers and colleagues
	Offer focussed support and guidance for leaders managing and staff working remotely in the longer- term post-pandemic.	Equal and fair access and provision of part time, job share, flexible and remote working arrangements.	Hybrid working and home working policy and toolkit	Deputy Director of Workforce	Before next GPG reporting period	People Committee	April 2023	Consultation has commenced in December 2022 on a new hybrid working and home working policy and toolkit, which will help in embedding flexibility in where and how people work going forward.

	Increase and showcase flexible working arrangements in the Trust, target staff groups or work areas under-represented to create a flexible working culture	Equal and fair access and provision of part time, job share, flexible and remote working arrangements.	Regular comms including Director briefings on flex working culture linking to health & wellbeing programme and branding	HRBP Comms Lead Deputy Director of Workforce	Before next GPG reporting period	People Committee	June 2023	The flexible working group will showcase flexible working arrangements which currently exist within the trust to raise awareness of what is possible as we work towards creating a flexible working culture across the organisation.
	Learn from other NHS organisations best practice case studies on flex working	Equal and fair access and provision of part time, job share, flexible and remote working arrangements	Best practice shared learning from case studies	HRBP Deputy Director of Workforce	Before next GPG reporting period	People Committee	June 2023	The flexible working group will take learning from best practice areas and national toolkits to champion, showcase and pilot case studies to the Trust
	Identify and increase recognition and support for staff who are carers to identify what issues they face	Increased recognition and support for staff who are carers	Revised carers leave policy	HRBP Deputy Director of Workforce	Before next GPG reporting period	People Committee	Feb 2023	Increased carers leave provision in revised family friendly policy Proposal Paper to go to Executive Team in Jan 2023

	Identify and increase recognition and support for staff who are carers to identify what issues they face	Set up peer support group and access to resources and information for staff who are carers	Working Carers support group	Head of Inclusion and Wellbeing HWB Coordinator HRBP	Before next GPG reporting period	People Committee	Completed	In November 2022 we launched our carers support group to raise awareness and increase recognition and support of staff who are carers, to identify what issues they face, to lead to improved engagement and retention
	Identify and increase recognition and support for staff who are carers to identify what issues they face	Profile and analysis of staff who are working carers and their needs & support in work is in place.	Use of ESR functionality to enable an employee to add a working carer competency and a working carer passport holder competency in ESR.	Workforce Planning & Information Manager Head of Inclusion & Wellbeing	Before next GPG reporting period	People Committee	June 2023	We are planning to present the ESR working carer passport to the carers support group to gauge interest in using the functionality
	Develop and refine the Trust's approach to talent management	Identification of top talent and their access to	A plan outlining the Trust's	Head of Leadership & Organisational	Before next GPG reporting	People Committee	March 2023	A high-level talent management and succession

	and succession planning to help support career progression and the Trust's ability to fill critical roles.	leadership development programmes, structured career coaching conversations, work shadowing opportunities, work mentors and coaches.	approach for developing a structured talent and succession management process.	Development	period			planning approach will be included as part of the Organisational Development (OD) Strategy by end of March 2023. We are also planning to expand our internal Coaching and Mentoring capability as part of the OD strategy, which will provide more support for the career progression of our Talent.
	Offer a mentoring and buddying scheme for female and male consultants to encourage and support them with their Clinical Excellence Awards (CEAs) applications for the 2023 round	Consultant CEAs mentoring and buddying scheme established and being accessed by female and male applicants for the 2023 round	CEAs mentoring and buddying scheme Guide	Medical Staffing Manager	Before the launch of the CEAs 2023 round	People Committee	April 2023	A working group is to be established to develop the new process and offer a mentoring scheme from individuals who have previously been successful in their applications.

2.3. Quality and Governance Committee Chair's Log: 25 January 2023

For Assurance

Presented by Kevin Clifford and Bob Kirton

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/2.3

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
SPONSORED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
PRESENTED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

The Quality & Governance Committee (Q&G) is one of the key committees of the Board responsible for oversight of care quality and governance. Its purpose is to provide detailed scrutiny of quality and safety across the Trust in order to provide assurance and raise concerns (if appropriate) to the Board of Directors and to make recommendations, as appropriate, on quality and safety matters to the Board of Directors.

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on 25 January 2023 and received a number of presentations, regular and adhoc reports to provide the committee and ultimately the Board with assurance. This month's agenda being larger than usual due to the cancellation for operational reasons of the December meeting.

Q&G's agenda included consideration of the following items:

- Patient Experience and engagement and learning from experience reports
- Health Inequalities Action Plan Update
- Research and development update
- National Cancer Patient Experience Survey
- Mental Health Detentions Report
- Infection Prevention and Control
- Nursing, Midwifery and Therapy Services Report
- Maternity Services Board Measures Minimum Data Set
- Medical Staff Safeguards Report
- Pharmacy Staffing Update
- Mortality Report

For the purpose of assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Board of Directors is asked to receive and note the report.

1. Receive and review the attached Log; and
2. Approve the Reports as noted in the Log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	Ref:	BoD: 23/02/02/2.3

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 28 September 2022	**Chair:** Rosalyn Moore/Kevin Clifford

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Patient Experience & Engagement	The very challenging target of reducing communication complaints by 10% was discussed and assurance was sought on a number of issues related to this. In addition, the committee were pleased to hear that considerable improvements had been made in discharge complaints as well as good progress in response times, which had been achieved without any complaints needing to be opened. The committee heard about the good work with the Maternity Voice Partnership in Maternity and was assured this will become a template for improving engagement across the Trust. Coffee and Chat sessions have been recommenced.	Board of Directors	For Assurance
2	Health Inequalities Action Plan	The committee received its quarterly update on the health inequalities work and received considerable assurance that progress was continuing at pace. It was felt the next stage was a need to take some of these successful initiatives and implement them at scale. Within the CRR the recent decision to reduce the level of risk of inability to anticipate evolving needs of the local population and some concern was raised that this reduction may be premature until the plan was implemented but following explanation by Dr Snell of the logic for the reduction. The committee accepted and supported the reduction.		

3	Research & Development (R&D) Update	The committee received assurance of the continued good performance of R&D at the Trust, particularly when compared with similar sized non-teaching Trusts. Financially, the performance has also been slightly better than expected. Recently we have been able to bid for CRN capital monies, which if successful would help towards developing a high-quality Research Hub.	Board of Directors	To Note
4	National Cancer Patient Experience Survey	The committee received the results of this survey as in previous years, which while there continued to be very positive feedback on our patients' experience the response rate was somewhat lower this year. The committee did request sight of any action plan which resulted from the findings which weren't included in this report.	Board of Directors	For Assurance
5	Mental Health Detentions Report	The committee received the routine report on the Mental Health Detentions undertaken by the Trust. Assurance was provided that all our detentions were appropriate and legal and unlike previous reports which identified minor administrative issues, these appear to have been largely eliminated. The paper led to a wider discussion around specific challenges relating to capacity in specialist Mental Health services which do sometimes impact our teams.	Board of Directors	For Assurance

6	Infection Prevention and Control (IP&C)	The committee received the IPC Meeting minutes and sought further assurances on both C-Dif and Antimicrobial Stewardship. The C-Dif threshold for this year, in common with many Trusts, had been exceeded and we are now waiting for NHSE locally who have been tasked with developing an Action Plan for the North East and Yorkshire area. Antimicrobial stewardship; we are slightly above the antibiotic reduction target (by <1%) but it was felt a number of initiatives would help reduce this further. The committee also received an update on infection surveillance in surgery and the updated CPE Policy.	Board of Directors	For Assurance
7	Mortality report	The committee received the usual mortality report and discussed a range of issues arising from the report; including Specialist Palliative Care coding and Post Hospital Acquired Covid Deaths. The discrepancy between HSMR and SHMI was discussed, which appears to be in part attributable to specialist palliative care coding (Barnsley at 20% vs National 40%). A range of other actions were discussed.	Board of Directors	For Assurance
8	Clinical Staffing Reports	**Nurse Staffing:** remains challenging with the ED and MAUs affected by both vacancies and Maternity Leave a particular area of pressure. **Medical Staffing**: was particular concern raised regarding the reduction in Paediatric middle-grade doctors for the next period from March 2023 and the impact that will have on rotas and cover arrangements, with specific reference to the impact on the Neonatal unit **Pharmacy:** The committee discussed the implications of a number of vacancies across a number of grades. Particular concern was raised around the Aseptic Service, although this is not uniquely a Barnsley issue.		

		A wider conversation was begun around the range of changes currently occurring or soon to occur and the need to review establishments to meet a changing need. This was previously presented in November and the Chief Pharmacist committed to keeping the committee updated on progress.	Board of Directors	For Assurance
9	Maternity Services Board Measures Minimum Data Set (including Maternity Staffing Report)	The committee received and debated the usual data set and gained assurance on a number of issues currently being addressed in Maternity, including post-natal readmissions, the accuracy of safeguarding training data and out-of-date protocols. in addition, for information, the committee received the CNST paper considered by the Board in December. The committee where made aware that the final report of the previously reported Ockenden Assurance Visit had not yet been received.	Board of Directors	For Assurance
10	Trust Objectives 2022/23 Progress Report	The committee reviewed and agreed on the RAG rating of the quality-related items on the objectives. A significant part of the discussion concentrated on the small number of quality metrics that support the quality objectives. The committee agreed that at least one of the “red-rated” metrics was not, with hindsight, appropriate and was having a disproportionate effect on the RAG rating for the quality section overall. Discussion on how this could be remedied followed and will be taken up outside of the meeting	Board of Directors	For Noting

2.4. Finance and Performance Committee Chair's Log: 26 January 2023

For Assurance

Presented by Stephen Radford

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/2.4

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Stephen Radford, Non-Executive Director, Chair Finance & Performance Committee				
SPONSORED BY:	Stephen Radford, Non-Executive Director, Chair Finance & Performance Committee				
PRESENTED BY:	Stephen Radford, Non-Executive Director, Chair Finance & Performance Committee				

STRATEGIC CONTEXT

The Finance & Performance Committee (F&P) is one of the key committees of the Board responsible for Governance. Its purpose is to provide detailed scrutiny of financial matters, operational performance and indicators to provide assurance, raise concerns (if appropriate) and make recommendations on people, financial and performance matters to the Board of Directors.

EXECUTIVE SUMMARY

KEY:£k = thousands
£m = millions

This report provides information to assist the Committee and Board to obtain assurance regarding the finance and operational performance of the Trust and appropriate rigour of governance. The January meeting was held on 26th January 2023, via Zoom.

The following topics were the focus for discussion:

- Trust Financial Position
- Integrated Performance Report
- BAF and CRR
- Trust Objectives 2022/23
- Business Planning 2023/24
- ICT Strategic Programme Update and Minimum Digital Foundation
- Efficiency and Productivity Programme
- Mexborough Elective Orthopaedic Centre
- Sub-Group Chair Logs

The F&P Committee recommended the Mexborough Elective Orthopaedic Centre Short Form Business Case and Trust Objectives 2022/23 Progress Reports to the Trust Board for review and approval.

The F&P Committee also approved under delegated authority from the Trust Board the Minimum Digital Foundation (MDF) Investment Agreement for submission.

RECOMMENDATIONS

The Board of Directors is asked to receive and review the attached log.

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Subject:	**Finance and Performance Committee Chair's Log**	Ref:	**BoD: 23/02/02/2.4**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group	**Date 26th January 2023**	**Chair**
Finance and Performance Committee		**Stephen Radford, Non-Executive Director**

KEY: FTE: Full Time Equivalent; £k = thousands; £m = millions

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Integrated Performance Report	The Finance & Performance received the latest IPR report for December 2022 from which the following were noted: **IPR Review:** **Performance:** In December 2022, bed occupancy rose again to 92.2% from 91.3% the previous month for general and acute patients against a target of 85%. BHNFT continues to not meet constitutional targets and faces continuing pressure on urgent and emergency care pathways. The Trust response included the enactment of Gold & Silver command structures and suspension of the elective programme. **4-Hour UEC Target:** Overall 4-hour performance decreased further in December 2022 from November 2022 to 42.6%% from 54.0% against a target of 95%. National benchmarking places the Trust at 87/110 Trusts (from 57 in the previous month) for type 1 ED. The average time in the emergency department was 199 minutes (65/137), a reduction from 204 minutes in the previous month. **Ambulance Handover Performance**: Performance decreased in the month to 50.2% of ambulances turned around in <30 minutes from 58.3% in the previous month. This remains below the national objective of 95% of handovers within 30 minutes. This again reflects the strain being placed on the A&E service. **RTT:** Overall performance improved in the month to 80.4% against the 92% standard. The Trust has 0 patients waiting longer than 104 week and 3 at > 78 weeks which is a national operational priority for 22/23 and 110 patients waiting over 52 weeks. The Trust is within the top quartile for patients waiting >52 weeks.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Waiting List: The number of patients on the waiting list has remained static at 19597 against a planning target of 14500. DNA rate at 8.2 also worsened in the month from 7.5% the previous month. **Cancer:** Overall cancer 2-week waits improved in the month to 95.0% against a target of 93.0%, up from 92.0% last month. The Trust is at 69.0% against an 85% target for urgent 62-day urgent GP referrals, a significant improvement month on month. Cancer pathways and reducing the number of patients waiting longer than 62 days to commence treatment is a key focus area in Q3/4. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks for a diagnostic test has increased to 16.5%. against a target of 0% and from 6.0% the previous month. The Trust benchmarks nationally at 35 out of 156 Trusts Routine activity was stepped down over Xmas and New Year. **Complaints:** The Trust closed 65.2% of complaints against the 90% target of all formal complaints being responded to within 40 working days. A reduction in performance compared to the previous month of 86.4%. **Elective Recovery:** The Trust is behind plan from an ERF perspective and the recovery of activity against 2019/20 levels remains challenging. The recommencement of weekend orthopaedic lists is increasing inpatient elective work. There is a focus on day case activity & outpatient first appointments. **Workforce** **Staff Turnover:** The staff turnover rate at 11.8% remained static and is within the target range of 10-12%. **Sickness:** The sickness absence rate worsened in the month to 6.9% from 5.8% the previous month, and above the 4.5% target. **Mandatory Training**: The rate remained static at 87.3% and below the 90% target. **Staff Appraisal**: The rate remained static at 82.7% and below the 90% target.		
Trust Finance Report	The Finance & Performance Committee received the Trust Finance report and received assurance on the current financial position of the Trust for 2022-23. It was noted that: **Financial Position 2022-23:** In the year-to-date. the Trust has a consolidated deficit of £3.2m against a planned deficit of £5.6m giving a favourable variance of £2.4m against plan. NHS England	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	and Improvement (NHSE/I) adjusted financial performance is a deficit of £4.5m. The Trust remains on track per its financial plan. The year-end forecast continues to give an NHSE/I adjusted forecast of £8.8m deficit which is consistent with last month's forecast and the plan for the year **Total Income**: In the year-to-date, total income at £217.6m is £3.95m favourable to plan for the year. The favourable variance is mainly due to higher than expected recharges, training & education income, and grant income from the capital de-carbonisation scheme and the retention of ERF income. **Pay Costs:** In the year-to-date, pay costs are £161.0m with an adverse variance of £4.5m against plan. This is due to the impact of Covid, the opening of additional winter capacity, higher than planned levels of sickness absence, unachieved efficiency and expensive agency staff costs. For 2022/23 the Trust has now set an agency expenditure cap. In the year to date, £6.0m has been spent on agency, which is £0.56m above plan. The forecast for the year has been amended to £1.0m above the cap. **Non-Pay Costs:** In the year-to-date, these are £56.97m and £2.36m favourable to plan. Mainly due to activity levels being below those planned and not accruing for the costs of catching up on the elective activity recovery. **Capital Expenditure**: In the year-to-date, capital expenditure for the year is £5.4m, which is £0.8m favourable to plan. The underspend is mainly due to slippage on estates and IT schemes which are expected to recover during the year. **Cash Balances**: Cash balances were £37.8m and £24.2m ahead of plan in the year-to-date. This is mainly due to timings of payments to creditors, slippage on the capital programme and earlier receipt of NHS income.		
Efficiency and Productivity Programme (EPP)	The F&P Committee discussed and noted the progress on EPP. In the year-to-date, cumulative savings to date is £8.71m against a plan of £12.44m which gives a year-to-date negative variance of £3.73m. In the month, actual savings of £0.82m were achieved against a plan of £1.38m resulting in an unfavourable variance of £0.56m.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	For 2022/23,the overall programme forecast position has slightly reduced since last month from £11.98m to £11.97m, against the £16.59m target. Recurrency ratio is now revised to 90%, following a detailed review of the schemes. There are currently 80 schemes in the programme There are 49 schemes at full maturity or awaiting final sign off and there are 31 schemes in the pipeline. A number of productivity related saving schemes remains a risk, affected by significant operational pressures and strike action. CBUs have been asked to rapidly turn around a number of outline schemes with support from PMO and finance.		
Trust Objectives 2022/23 Progress Report	The F&P Committee received the 2022/23 Trust Objectives Quarter 3 update report and noted progress to date. The Finance & Performance Committee reviewed and approved the report, and commended the report to the Trust Board for approval. Key points noted included: • Trust has progressed well with the objectives there are however some challenges and risks but mitigation plans have been implemented where possible and necessary. • Good work across The Trust's support to a caring and supportive culture including the Equality, Diversity and Inclusion agenda has taken place. • Annual target to recruit further Professional Nurse Advocates and Freedom to Speak Up champions achieved • Delivery of the De-carbonisation (Salix) capital scheme is making good progress • Formal complaints regarding communication & failings in compassionate care continue to increase and are not reducing in line with ambitions • Positive actions are being taken performance against urgent care, whilst better than many Trusts, is not improving as expected and quarter 3 has seen a deterioration in performance across the UEC pathways due to the significant operational pressures	Board of Directors	For Review and Approval

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
BAF & CRR Updates	The F&P Committee received and reviewed updates made to Board Assurance Framework and Corporate Risk Register. It was noted that: • Following F&P in November 2022, risk 2592- the inability to deliver constitutional standards, it was decided to leave it on the BAF as a strategic risk and four new risks would be added to monitor performance operationally (four-hour target, RTT target, cancer and diagnostics). • 2 New risks added on the CRR– 2803 - risk to the delivery of effective haematology services due to a reduction in haematology consultants" and risk 2845 – inability to improve the financial stability of the Trust over the next two to five years • Risk 2605 risk regarding the Trust's inability to anticipate evolving needs of the local population to reduce health inequalities has been de-escalated on the CRR	Board of Directors	For Information and Assurance
ICT and Strategic Programme Update	A report summarising progress across a number of a significant number of projects was discussed. The Committee was provided with the assurance of progress being made in the delivery of our ICT strategic programme and any related risks. Key updates included: • Digital Funding Update: Frontline Digital Funding request for £6.2M over 3 Years was approved by the F&P Committee under delegated authority from the Trust Board for submission by end of January 2023 • Pathology Labs Information Management Solution: Strategy/business case being prepared for replacing the hardware for our BRILS Service Labs. Hardware is ageing and will need replacing before the single LIMS will be available for BRILS to implement. • Urgent Bleep Review: 60 Devices have now been delivered and implemented across the Trust. A pilot device was successfully trialled over the Christmas period. A full roll-out is planned to be completed by the end February 2023 • Replacement Endoscopy Solution: A business case for a replacement Endoscopy solution that will improve Clinical User experience was approved at ET and will now progress through the Trust governance process for approval • Robotic Process Automation (RPA): First RPA project has gone live - automatic referrals into MediViewer and Auto cancellation of appointments via 2-way texts. • MediViewer: Testing is under-way for the automatic loading of documents coming from Digital Dictation. This is planned to go live on the 1 February.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Minimum Digital Foundation (MDF) Investment Agreement	The Finance and Performance Committee, with Board delegated authority approved the detail submission of the MDF application for funding. Key points noted: • The Trust will be committed to a digital programme to deliver the technical and clinical transformational changes required to meet the MDF digital standards mandated by the secretary of state by 2025. (the Minimum Digital Foundations (MDF) • Three year period funding total is £6.25M, with £2.653 in the first year. • MDF aligns with the Trust's digital transformation strategy. • Investment Application document that will be submitted on approval is for year 1 funding only with strong reference to future years funding. • An update will follow to the Executive Team and F&P Committee in February 2023.	Board of Directors	For Information and Assurance
Mexborough Elective Orthopaedic Centre (MEOC) Business Case	The Finance and Performance Committee received the report on the MEOC covering the initial business case and outline of the proposed Scheme. Key points: • F&P reviewed the business case and direction of travel towards the development of a dedicated 'green' site for Orthopaedic electives. • Proposed partnership working arrangement between the three Trusts.(Doncaster/ Rotherham/ Barnsley) • Capital spend associated with the business case, noting that further work will be required to determine revenue. • That routine updates will be presented to the Executive Team as the project progresses for oversight, assurance and where required decision-making • The facility will deliver inpatient and day case activity and is intended to reduce elective orthopaedic waiting lists/ waiting times and Improve productivity and efficiency The Finance and Performance Committee recommended the MEOC outline business case to the Trust Board for review and approval.	Board of Directors	For Review and Approval
Sub Group Logs	The Committee received the following sub-group logs/updates: • Executive Team	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	• BFS • Capital Monitoring group • Careflow Steering Group • CBU Performance Meetings • Trust Operations Group		
Business Planning Update 2023/24	The Finance and Performance Committee received an update on the progress to date on the preparation of business plans for 2023/24. The Committee received assurance that plans remain on track. The Committee also noted the key national objectives for 2023/24.	Board of Directors	For Information and Assurance

2.5. Barnsley Facilities Services Chair’s Log

For Assurance

Presented by Sue Ellis

REPORT TO THE BOARD OF DIRECTORS (BHNFT)	REF:	**BoD: 23/02/02/2.5**

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Sue Ellis, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	Sue Ellis, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	Sue Ellis, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

Barnsley Facilities Services Ltd (BFS), (formerly Barnsley Hospital Support Services Limited BHSS), was established in 2012 as a wholly owned subsidiary of Barnsley Hospital NHS Foundation Trust (BHNFT) and became operational from January 2013. In addition to providing essential services to the Trust, it is intended as a vehicle to expand commercial opportunities and income streams for the benefit of patient services.

EXECUTIVE SUMMARY

The aim of this report is to provide the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns.

The enclosed Log reflects the discussions from the BFS Board's meeting in December 2022.

We reviewed the performance and the current financial position, which are both mainly positive.

The Board also formally considered options prepared by the Chief pharmacist, and approved the advancement of the electronic outpatient prescribing part of the Trust adoption of Careflow Medicines Management – Electronic Prescribing Medicines Administration (CMM-EPMA).

RECOMMENDATION

BFS Board recommends that:

- The Board of BHNFT notes the attached report and take assurance that Barnsley Facilities Services is performing to plan and budget.

REPORT TO THE BOARD OF DIRECTORS AND F&P BFS (BHSS) Chair's Log - Public Board	REF:	BoD: 23/02/02/2.5

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: BFS Board Meeting	**Date:** December 2022	**Chair:** Sue Ellis

Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1. **Performance Report**	**The Patient-Led Assessments of the Care Environment (PLACE) -** A PLACE working group was established and led by the Head of Facilities, with training undertaken for assessors. The assessment was completed on 15 November 2022; results have now been submitted via the online portal. A date has yet to be determined for the final results to be issued/published. **Critical Care Unit -** Following an extension of time request from the contractor from 31 January 2023 to 13 February 2023, this has been agreed as a project longstop. Intensive Care Team members continue to attend the site as part of their two weekly visits and remain excited about the changes in the development. **Decarbonisation -** Decarbonisation schemes for the outer blocks are planned with decants required for some non-clinical staff to other premises. These will commence in January 2023. **Medical and Surgical Equipment (Capital) –** Each CBU has prioritised bids for consideration, and BFS continues to work with Trust finance on the current asset register. A decision-making meeting was to be held in December to enable procurement teams to commence purchasing.	Board of Directors	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2.	**Finance**	It remains anticipated that BFS will achieve the planned profit for the year 22/23. As detailed under the Performance report section, both the Materials Management and Contracting and buying teams remain extremely busy and have made some significant savings and taken cost avoidance actions for the benefit of BHNFT.	Board of Directors	For Information and Assurance
3.	**People**	The cumulative turnover rate was 12.7%. The end of November sickness figure is 4.9% which is a decrease from a figure of 5.9% the month before. The numbers of both long and short-term cases have reduced. Training compliance is well sustained at 92.1%	Board of Directors	For Information and Assurance
4.		The deployment of Careflow Medicines Management – Electronic Prescribing Medicines Administration (CMM-EPMA) across the Trust affords the opportunity to deploy electronic prescribing in the Trust's Outpatient Pharmacy service. Trust Chief Pharmacist has now supported the system and recommended the rollout within Outpatient Pharmacy with noted patient safety benefits from deploying this prescribing functionality. After considering a number of options, the BFS Board approved the roll-out of the CMM-EPMA system prior to the development of the advanced electronic signature functionality, based on the recommendations of the Trust Chief Pharmacist, legal representatives, and the respective groups. The detailed development of electronic digital signature functionality on CMM is being identified in the work plan for 2023.	Board of Directors	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS (BHNFT)	REF:	**BoD: 23/02/02/2.5i**

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	2 FEBRUARY 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Sue Ellis, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	Sue Ellis, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	Sue Ellis, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

Barnsley Facilities Services Ltd (BFS), (formerly Barnsley Hospital Support Services Limited BHSS), was established in 2012 as a wholly owned subsidiary of Barnsley Hospital NHS Foundation Trust (BHNFT) and became operational from January 2013. In addition to providing essential services to the Trust, it is intended as a vehicle to expand commercial opportunities and income streams for the benefit of patient services.

EXECUTIVE SUMMARY

The aim of this report is to provide the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns.

The enclosed Log reflects discussions from the BFS Board's meeting in January 2023.

The routine performance part of the Board was abbreviated to enable the strategic discussions to continue on next year's Business plan, and BFS year-end position.

In the workshop session we were joined by Chris Thickett, Finance Director of BHNFT who is to become our link Trust Director going forwards. We reviewed our progress against 2022/3 objectives and firmed the timeline to agree the 23/24 Business plan.

RECOMMENDATION

BFS Board recommends that:

- The Board of BHNFT notes the attached report and take assurance that the wholly owned Operated Healthcare Facility is performing to plan and budget.

REPORT TO THE BOARD OF DIRECTORS AND F&P - BFS (BHSS) Chair's Log - Public Board	REF:	BoD: 23/02/02/2.5i:

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: BFS Board Meeting	**Date:** January 2023	**Chair:** Sue Ellis

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.	**Performance Report**	**Cost Improvement and Efficiencies -** Work has begun on identifying cost improvement and efficiency schemes for 2023/24. A challenging target is expected and the team have started to populate a CIP ideas template and have been encouraged to think of 'out of the box' ideas for scoping. The **Contracting and Buying** team have again been extremely busy this month. **Portering KPI Performance (November 2022) -** Generally good performance in November, with the slight exception of 'Patient Movements Responded to Within 20 Minutes', which was at 83.4% against a target of 85%; however as noted below this was in a context of high volumes of work. Winter Pressures – There has been significant increase in patient numbers, with a peak bed occupancy of 531 beds on 2 January 2023, and service position has been sustained although challenging alongside staff sickness and leave. The Portering Team and the Estates Team have supported the reintroduction of Ward 32 as an escalation space. The Board expressed thanks to all staff for their efforts as all teams have been stretched.	Board of Directors	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		Estates KPI Performance (November 2022) – Despite a number of vacancies remaining (these include Joiners, Decorators and a Mechanical Fitter), the Estates Team achieved all KPI measures for the second consecutive month. **Decarbonisation –** Works have commenced on the Estates block roof to install external pipework for the heat pump. Some staff have decanted to offsite office accommodation at Gateway Plaza to accommodate the work.		
2.	**Finance**	The financial position remains on target and as previously reported it is anticipated that BFS will achieve the planned profit for the year 22/23.	Board of Directors	For Information and Assurance
3.	**People**	The cumulative turnover rate was 11.2 %, slightly above target of 10%. However, it was noted that a number of staff have had career advancement; taking up opportunities within the Trust Group. The end of December sickness figure is 5.93% which is an increase from a figure of 4.9% the month before. The change reflects an increase in short term absences (rising from 21 case to 58 and amounting to 74% of the sickness cases). The main reason for such absence was recorded as cold, cough, flu, which accounted for 28.85% or 15 absences, followed by chest and respiratory problems which accounted for 19.23%. Training compliance is well sustained and above target at 92.4%	Board of Directors	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
4.	**Leadership**	The Board were delighted that Rob McCubbin current Operations Director has been appointed as Managing Director of BFS from April 2023, following a rigorous external recruitment process.	Board of Directors	For Information and Assurance

2.6. Executive Team Report & Chair’s Log

For Assurance

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS - *Public*	REF:	BoD: 23/02/02/2.8

SUBJECT:	**EXECUTIVE TEAM CHAIR'S LOG**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

Our vision is to provide outstanding, Integrated care. The Executive Team meets on a weekly basis to ensure the smooth day to day running of the Trust and ensure the Trust is delivering on the vision through its oversight and decision making.

EXECUTIVE SUMMARY

Board has previously been updated on matters considered at the Executive Team (ET) meetings by exception, usually verbally, on the basis that almost all matters are covered in other Assurance Committee reports, Board Reports or the IPR. This is the report of a more traditional Chair's Log approach and covers the ET meetings held in December 2022 and January 2023.

The Chair's Logs do not cover the routine weekly performance monitoring, updates or embedded Gold meetings unless the matters are sufficiently significant to require escalation. The COVID-19 Gold meetings are held within the ET allocated time for expediency but are separate from normal ET business and the separate COVID-19 Board report will provide Board with details of the Trust's pandemic response.

RECOMMENDATION

The Board of Directors is asked to receive and review the attached log.

CHAIR'S LOG: Chair's Key Issues and Assurance Model - Public

Committee/Group	Date	Chair
Executive Team	December 2022 – January 2023	Richard Jenkins

22/940	**Proposal Paper: Lead Midwife Fetal Well-Being**	The Lead Midwife for Fetal Wellbeing is currently provided by a 0.4wte Midwife on a rolling one year secondment. The responsibilities of this role increased following CNST and the Ockenden Inquiry. If ET support the recommendation for funding of 1wte, Lead Midwife for Fetal Wellbeing it will enable the postholder to drive improvement, provide hands on support and deliver regular training to all staff groups. The purpose for the post aligns with the recommendations from the Ockenden report therefore any funding requests must come from the Ockenden allocation. ET supported the recommendation to recruit to 1wte. There was a request that any supporting documentation provides clear mitigation for instances when the postholder is off sick/annual leave.
22/946	**Implementing Friends and Family Test Via SMS Messaging**	The report was taken as read. The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people use NHS services should have the opportunity to provide feedback. The Executive Team is asked to consider the options identified in this paper regarding Trust-wide implementation of FFT SMS text messaging. The preferred option from the Patient Experience Team is to proceed with either Healthcare Comms (SMS messaging) or Healthcare Comms (SMS/IVM messaging). Either of these would be an ideal solution to ensure suitable patient feedback. ET noted the potential costs of running this solution and also considered ways in which it could link in to other existing initiatives supported by Healthcare comms. Members supported option 3: Healthcare comms: SMS Messaging with link and online access.

3. Performance

3.1. Integrated Performance Report

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/3.1

SUBJECT:	**INTEGRATED PERFORMANCE REPORT**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Lorraine Burnett, Director of Operations				
SPONSORED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive				
PRESENTED BY:	Lorraine Burnett, Director of Operations				

STRATEGIC CONTEXT

The monthly Integrated Performance report is aligned to the trust objectives and informs the Board of Directors on key delivery indicators against local and national standards.

The report is currently being developed to reflect 3 of the 6 'P's' as per the trust strategic objectives. The report does not currently contain metrics directly related to Place & Planet as these are reported separately, with all objectives reported quarterly via the strategy report. The place dashboard is shared as available.

EXECUTIVE SUMMARY

The pressure in urgent and emergency care pathways have been widely reported on a national level with a particular focus on long ambulance delays and overcrowded emergency departments. BHNFT started to see an increase in demand mid November with a huge rise in paediatric attendances linked to the increase in Strep A infections and reported deaths. This continued into December with a peak in daily attendances on 5th December 2022 at 399. The attendance numbers converted to admissions with most days seeing c15% more medical admissions than expected. The surge in respiratory infections alongside a rise in patients >75 years meant high acuity and most patients requiring ongoing acute level care. The high prevalence of illness also increased staff sickness across all areas.

The trust saw increased waits for beds with numerous patients waiting longer than 12 hrs from a decision to admit (63 breaches in December 2022). The week beginning the 26th December the trust admitted 91 patients more than discharged.

Actions taken include: Gold & Silver command structures were enacted, the elective programme was suspended, the elective orthopaedic ward was utilised as a medical ward, the discharge unit was utilised for 8 inpatient beds, wards were required to accommodate 1 or 2 extra patients following an appropriate risk assessment, the expansion space on ward 32 adjacent to critical care was repurposed, initially to support restarting electives but then required as further medical capacity. Performance metrics dropped considerably as the trust focused on patient safety and supporting staff wellbeing.

System Control Centres were opened on 1st December under NHSE winter plans. This added a further layer of communication with oversight of ambulance pressures in South Yorkshire and requests to divert across different providers to manage waits.

Patients: There were 3 serious incidents in December, remaining within common case variation. Investigations are underway, duty of candour commenced and any learning will be shared appropriately:

- sub-optimal care of a deteriorating patient
- potentially avoidable inpatient fall
- hospital-acquired category three pressure ulcer

The number of falls continues to be at the upper process limit. There were 0 harmful falls in month. All wards are within normal variation.

There were 8 Hospital Acquired Clostridioides difficile which is above target. All are being investigated to determine factors and ensure any learning. There have been 39 cases in 2022/23. There were 0 MRAS cases in month, there have been 3 cases in year.

Pressures Ulcers are within common cause variation. The Hospital Acquired Category 2s with lapses continue to increase as do Deep Tissue Injury. However, the number of reported pressure ulcers has also increased for the month. Ward 30 has had a spike in their SPC however multiple pressure ulcers developed on the same patient, causing the rise. Other factors include: Patient acuity, Staff shortages – Ward 30 in particular running with a lot of NHSP and high levels of enhanced care patients. The Tissue Viability Nurse has worked on Ward 30 to help with education at the bedside whilst helping with patient care.

Time to answering complaints is below target but this month covers the Xmas and NY holiday period.

People: Staff turnover remains under 12% for third consecutive month. Sickness rates remain above target. Appraisal compliance has shown steady improvement. Planning is underway for next year. Mandatory training remains slightly below target.

Performance: The trust continues not to meet constitutional targets but benchmarks well against other trusts for the majority of metrics.

Performance against 4hrs has dropped further in December due to increased attendances, acuity & complexity of patients and lack of bed availability. National benchmarking- 87/110 trusts for type 1 ED. All metrics have deteriorated in month. The focus has been on maintaining the safety of patients and staff, listening to concerns and ensuring wellbeing support is in place for all staff. Gold and Silver command processes were re-established, all non-essential meetings cancelled and a considerable period of time was spent on OPEL 4.

A number of patients waited over 12 hours from decision to admit whilst the trust suspended its elective surgery, opened additional bed capacity, fully utilised any extra beds and the full capcity protocol on an almost daily basis towards the end of December.

BHNFT has 0 patients waiting longer than 104 week and 3 at > 78 weeks which is a national operational priority for 22/23. There is yet to be a recovery of the 18 week target but the waiting list size has stabilised. The trust is within the top quartile for patients waiting >52 weeks. Following regional NHSE meetings there is a focus on productivity and the trust is developing plans to deliver on the operational requirements in 2023/24.

The diagnostic waiting time is a key driver for recovery and the trust continues to focus on improvement against the aim to have no more than 5% of patients waiting longer than 6 weeks. The endoscopy service are working with a monthly reduction trajectory that will be overseen at executive level and should also support achievement of the target by March 23. In month the diagnostic target has deteriorated due to the number of bank holidays and the cancellation of routine activity to support emergency care pressures.

Cancer pathways and reducing the number of patients waiting longer than 62 days to commence treatment is a key focus in Q3/4. Booking rules have been changed to support 1st appointment within 7 days for 2 week wait referrals. A number of specialities have also introduced triage and straight to test pathways. These actions will support reducing pathway length and recovery of performance once the long waiting patients have been treated. The trust has c50 patients over 62 days which was the national expectation for BHNFT, we continue to strive for an improved position, planning for no more than 25 patients waiting over 62 days by end March 23.

The recovery of activity against 2019/20 levels remains challenging. The recommencement of weekend orthopaedic lists is increasing inpatient elective work. There is a focus on day case activity & OP first appointments with weekly oversight meetings to ensure optimum booking processes. QI methodology is being used to increase theatre utilisation and understand the barriers to further improvements. A number of pathway changes are being explored to understand if these have contributed to a reduction against 19/20 activity.

Finance: As at month 9 the Trust has a consolidated year to date deficit of £3.217m against a planned deficit of £5.674m giving a favourable variance of £2.457m. NHS England and Improvement (NHSE/I) adjusted financial performance after taking into account income and depreciation in respect of donated assets £0.062m and granted assets (£1.414m), is a deficit of £4.569m with a favourable variance of £1.105m.

Total income is £3.950m favourable to plan for the year. The majority of clinical income is subject to block arrangements and system allocations. The favourable variance is mainly due to higher than expected recharges and training & education income, along with grant income in respect of the capital decarbonisation scheme; partly offset by providing for a potential income clawback risk.

Cash balances have decreased from last month by £3.329m, although the year to date favourable variance against plan has decreased by £0.986m which is mainly due to timings of payments to creditors, slippage on the capital programme and receipt of NHS income.
Capital expenditure for the year is £5.472m, which is £0.805m below plan. The underspend is mainly due to slippage on estates and IT schemes which are expected to recover during the year.

The Trust are posting an NHSE/I adjusted financial performance deficit of £4.569m, however, there are several non-recurrent costs and benefits within this position which mask the true underlying performance. Adjusting for all of these would result in a “real” position of £11.547m deficit. Forecast, most likely case, remains a £5.2m deficit which continues to give a NHSE/I adjusted forecast of £8.8m deficit consistent with plan and last month’s forecast; with a NHSE/I best case £4.1m deficit and worst case £9.8m deficit.

RECOMMENDATIONS

The Board of Directors is asked to receive and note the Integrated Performance Report.

Barnsley Hospital NHS Foundation Trust

Patients | Partners | People | Performance | Place | Planet

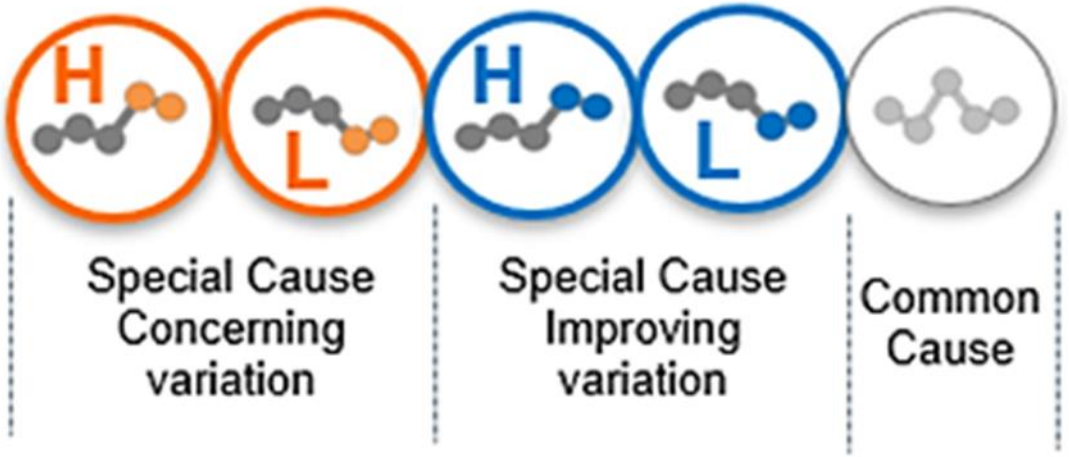
PROUD to care

Barnsley Hospital Integrated Performance Report

Reporting Period: December 2022

Assurance

Performance



High Level Assurance

Can we reliably hit the target?

Blue = will reliably hit the target

Orange = System change required to hit the target

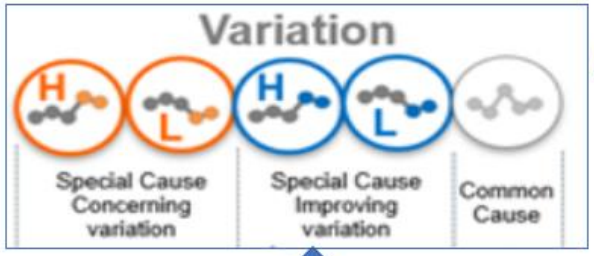
Grey = will hit and miss the target

High Level Key Performance

Are we improving, declining or staying the same?

Orange = Significant concern or high pressure

Grey = No significant change



Blue = Significant improvement or low pressure

Summary icon descriptions

Assure	Perform	Description
		Special cause of an improving nature where the measure is significantly **HIGHER**.This process is still not capable. It will **FAIL** the target without process redesign.
		Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.
		Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of an improving nature where the measure is significantly **LOWER**.This process is still not capable. It will **FAIL** the target without process redesign.
		Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.
		Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or worse performance. However despite deterioration the process is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or worse performance. This process will not consistently hit or miss the target. This occurs when target lies between process limits.

Summary icon descriptions

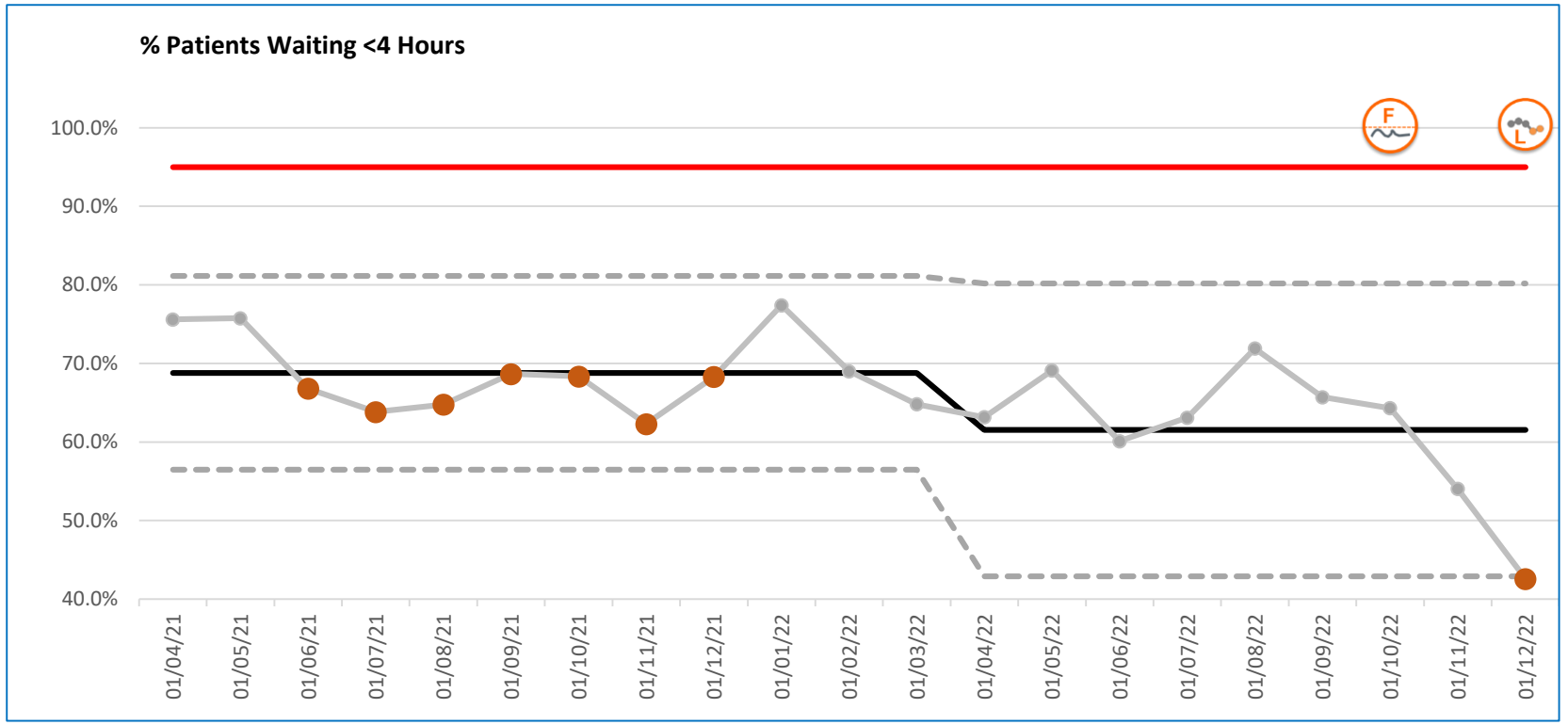
Assure	Perform	Description
		Special cause of a concerning nature where the measure is significantly **LOWER**.This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **LOWER**. However the process is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Common cause variation, no significant change.This process is not capable. It will **FAIL** to meet target without process redesign.
		Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.
		Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Means and process limits are calculated from the most recent data step change.

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Serious Incidents	Dec 22	3	0			2	-3	7
Incidents Involving Death	Dec 22	2	0			1	-3	5
Incidents Involving Severe Harm	Dec 22	1	0			1	-3	6
Never Events	Dec 22	0	0			0	0	0
Falls	Dec 22	108	65	F		103	69	137
Falls Resulting in moderate harm or above	Dec 22	0	15	P		2	-2	6
Pressure Ulcers category 2 (Lapses in care)	Nov 22	14	4	F		11	5	18
Pressure Ulcers category deep tissue Injury	Nov 22	7	4			6	1	11
Hand washing	Dec 22	97%	95%			98%	95%	102%
Q - Hospital Acquired Clostridioides difficile	Dec 22	8	2			4	-2	11
Q - Hospital Acquired MRSA Bacteraemia	Dec 22	0	0			0	-1	1
Number of complaints	Dec 22	19				24	6	41
Complaints closed within standard	Dec 22	65.2%	90.0%			66.8%	38.0%	95.7%
Complaints re-opened	Dec 22	0	0			0	0	0
FFT Trustwide Positivity	Dec 22	90.1%				89.4%	79.4%	99.4%
Staff Turnover	Dec 22	11.8%	12.0%		L	12.3%	11.8%	12.7%
Appraisals - Combined	Dec 22	82.7%	90.0%			65.2%	16.8%	113.5%
Mandatory Training	Dec 22	87.3%	90.0%	F		87.3%	85.1%	89.5%
Sickness Absence	Dec 22	6.9%	4.5%			6.3%	4.2%	8.3%

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
% Patients Waiting <4 Hours	Dec 22	42.6%	95.0%	F	L	61.6%	42.9%	80.2%
RTT Incomplete Pathways	Nov 22	80.4%	92.0%	F		81.1%	78.4%	83.7%
RTT 52 Week Breaches	Nov 22	110	0	F	H	71	46	96
RTT Total Waiting List Size	Nov 22	19597	14500	F	H	18547	17554	19540
% Diagnostic patients waiting more than 6 weeks	Dec 22	16.5%	1.0%	F		12.8%	2.7%	22.9%
% Cancelled Operations	Dec 22	0.4%	0.8%	?		0.8%	-0.2%	1.8%
DNA Rates - Total	Dec 22	8.2%	6.9%	F		8.9%	7.4%	10.4%
Average Length of Stay - Elective - Spell	Dec 22	4.0	3.5	?		3.0	1.7	4.2
Average Length of Stay - Non-Elective - Spell	Dec 22	4.0	3.5	?		3.7	3.2	4.3
Bed Occupancy General and Acute % Overnight	Dec 22	92.2%	85.0%	F	L			
Total Number of Ambulances	Dec 22	1919	-	F	L	1984		
% Less than 30 mins	Dec 22	50.2%	95.0%			62.4%		
% Greater than 30 mins	Dec 22	16.8%	-	F		17.1%		
% Over 60 mins	Dec 22	21.4%	-	F		9.3%		

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
All Cancer 2 Week Waits	Nov 22	95%	93%	?		91%	84%	99%
Breast Symptomatic	Nov 22	90%	93%	?		90%	78%	102%
31 Day - Diagnostic to 1st Treatment	Nov 22	96%	96%	?		93%	86%	101%
31 Day - Subsequent Treatment (Surgery)	Nov 22	85%	94%	?		87%	67%	107%
31 Day - Subsequent Treatment (Drugs)	Nov 22	100%	98%	?		98%	89%	108%
38 Day - Inter Provider Transfer	Nov 22	54%	85%	F		56%	36%	75%
62 Day - Urgent GP Referral to Treatment	Nov 22	69%	85%	?		65%	42%	87%
62 Day - Screening Programme	Nov 22	89%	90%	?		84%	56%	112%
62 Day - Consultant Upgrades	Nov 22	88%	85%	?		85%	66%	104%
28 Day - Two Week Wait	Nov 22	73%	75%	?		70%	57%	84%
28 Day - Breast Symptomatic	Nov 22	100%	75%	P		97%	86%	109%
28 Day - Screening	Nov 22	73%	75%	?		62%	27%	97%



December 2022

42.6%

Variance Type

Special concern of a concerning nature where the measure is significantly LOWER. This occurs where there is deteriorating performance. The system is not capable and will FAIL the target without system change.

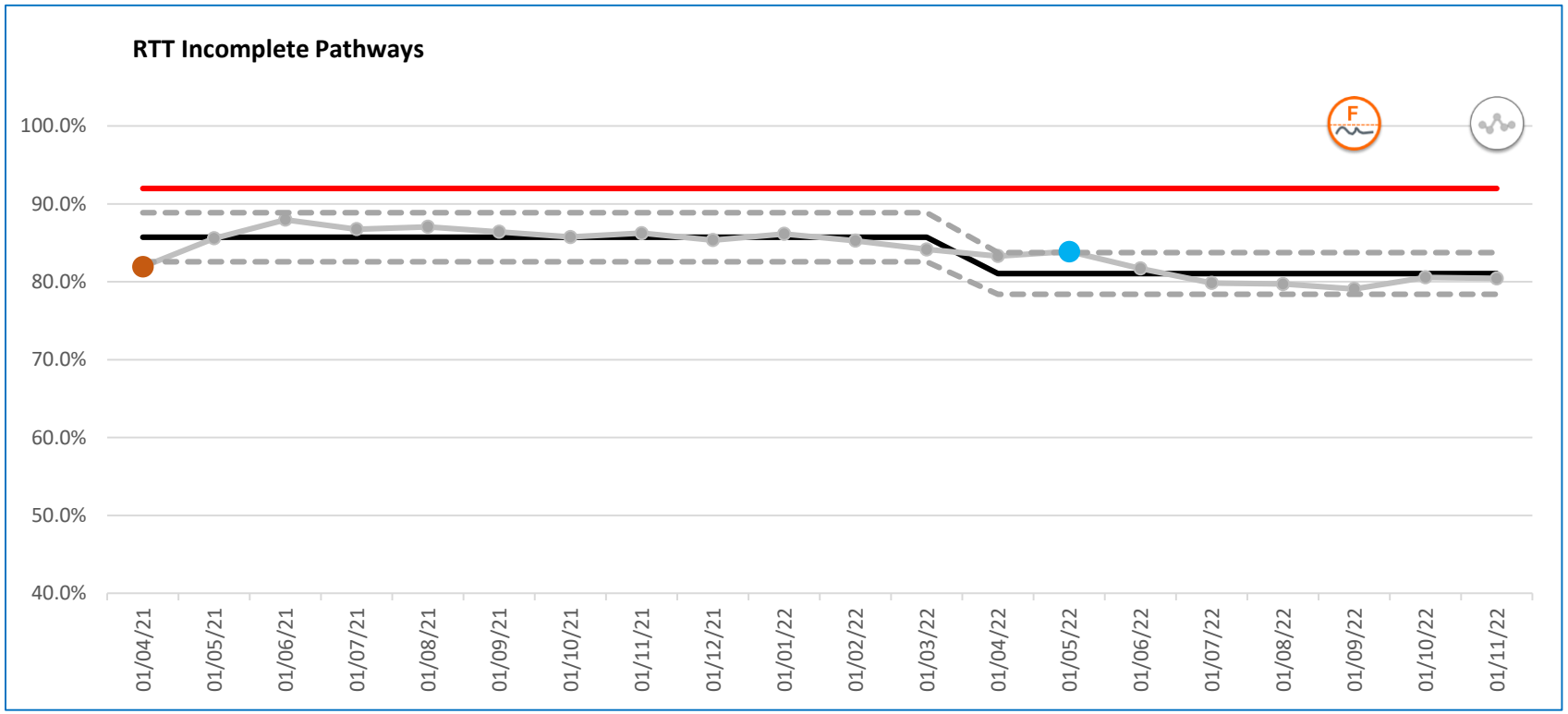
Target

95%

Target Achievement

Metric is consistently failing the target

Background	What the chart tells us:	Issues	Actions	Context
Emergency Department patients waiting <4 Hours	Remains below target and will not reach the target without system and/or process change. Consistently performing at lower process limit.	Patient acuity. Short notice staff absence. Less experienced workforce. Timely bed availability. Surge in attendances. High respiratory illness. High paediatric attendances. Increased demand for admission.	Ongoing workforce reviews, rota changes and recruitment to vacancies. Working with Barnsley partners. Focus on patient & staff experience & minimising risk of avoidable harm. National winter improvement collaborative. Suspension of elective activity. Additional bed capacity opened.	National benchmarking- 87/110 trusts for type 1 ED Average time in dept 199 minutes (65/137) Conversion rate to admission 28.1% (132/144) Additional bed days >7 days length of stay 80 (6/121)



November 2022

80.4%

Variance Type

Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

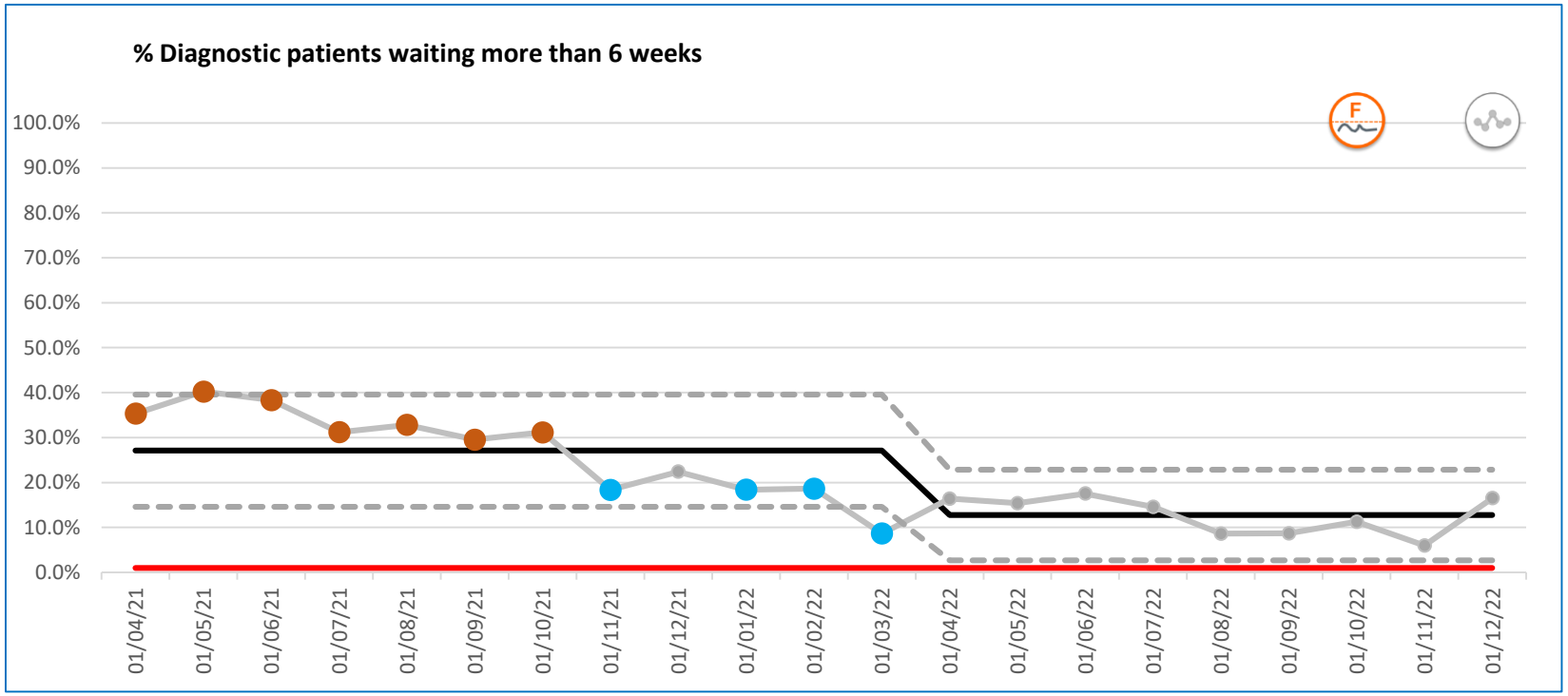
Target

92%

Target Achievement

Metric is consistently failing the target

Background	What the chart tells us:	Issues	Actions	Context
RTT Incomplete Pathways	Performance fallen below upper process limit and will not hit the target without system and /or process change.	Size of wait list increasing. Increased complexity of procedure due to wait time, co-morbidities and becoming unfit for surgery. Increased focus on clinical priority, urgent & cancer. Workforce gaps.	T&O elective suspended to create additional medical beds. Insourcing for specific specialities. Use of clinical prioritisation protocols. Bi-weekly oversight meetings. Forward planning for patients >50 weeks.	National benchmarking - 26th / 168 0>104 week waits >78 week waits – 3 >52week waits - 110 My Planned care App contains average waits by speciality



December 2022

16.5%

Variance Type

Common cause variation, no significant change.This process is not capable. It will FAIL to meet target without process redesign.

Target

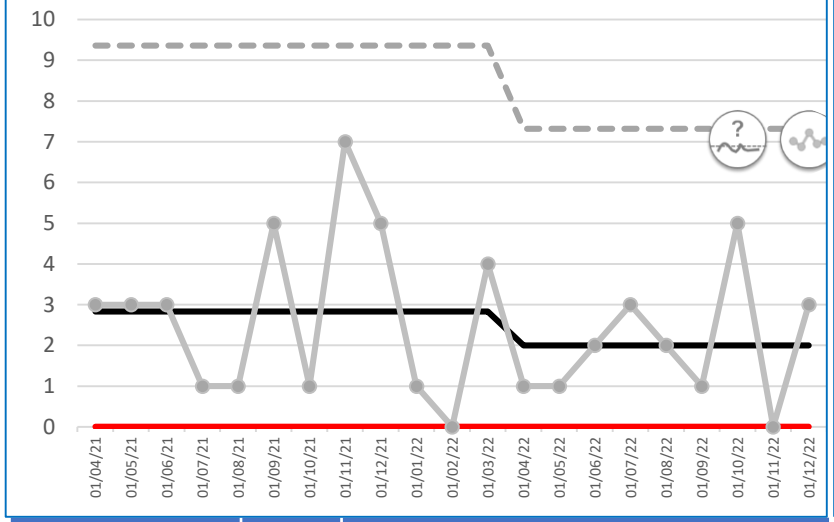
0.0%

Target Achievement

Metric is consistently failing the target

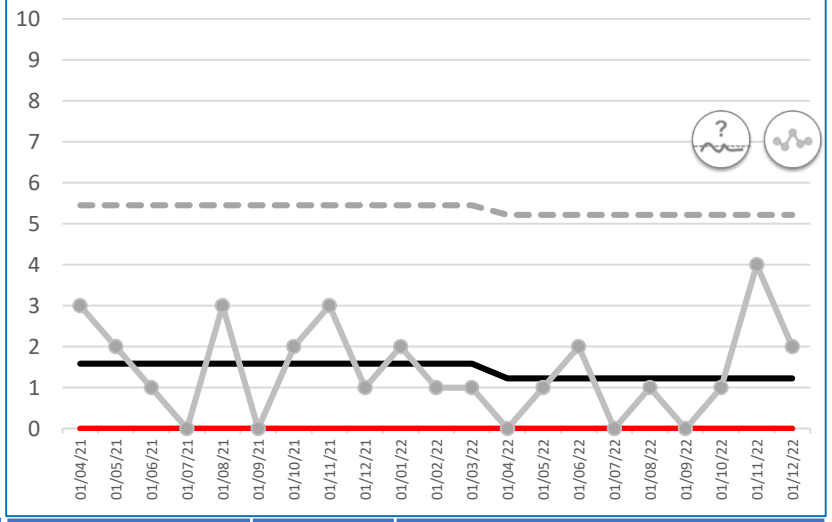
Background	What the chart tells us:	Issues	Actions	Context
Diagnostics	There is a sequential improvement but will hit target with continued action.	Backlog of activity following suspension of activity in Apr 2020. Prioritisation of cancer & urgent work. Increased demand due to rise in OP referrals.	Ongoing priority for cancer & urgent to support 'straight to test' to reduce cancer wait to treatment times. Focus on validation & reporting. Loss of Dec activity due to Bank Holidays and surge in emergency attendances. Additional capacity in imaging offered to SY trusts.	National benchmarking – 35/156 Routine activity stepped down over Xmas and NY

Serious Incidents



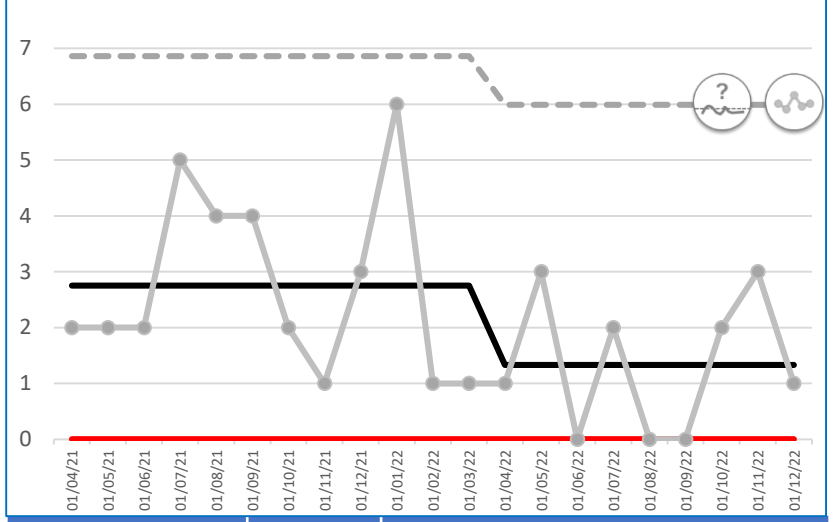
December 2022	Target	Variance Type
3	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Incidents Involving Death



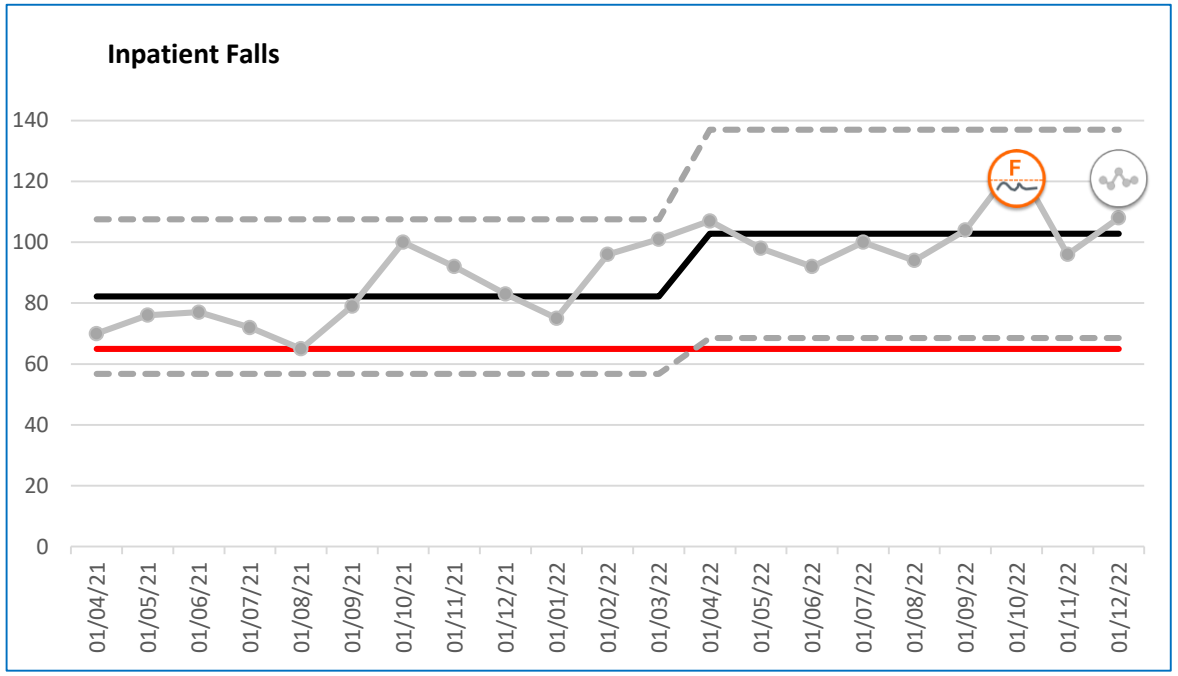
December 2022	Target	Variance Type
2	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

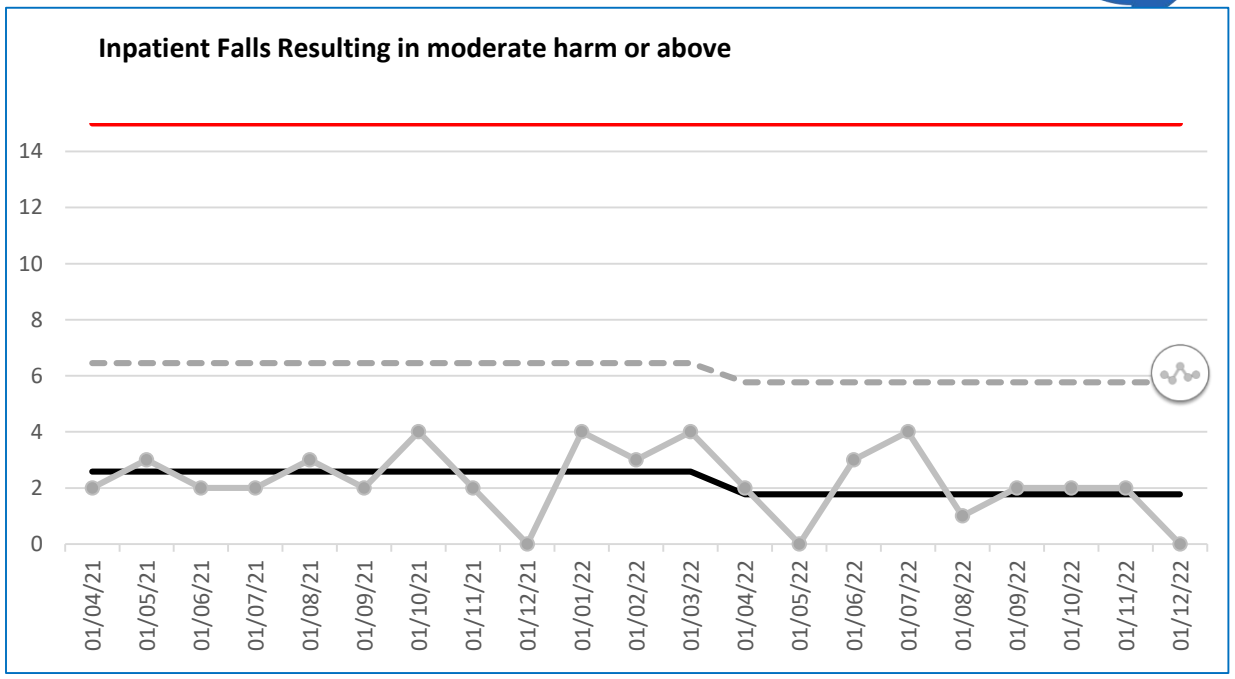
Incidents Involving Severe Harm



December 2022	Target	Variance Type
1	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Background	What the chart tells us:	Issues	Actions	Context
Serious Incidents	There were three serious incidents reported in the month: - sub-optimal care of a deteriorating patient - potentially avoidable inpatient fall - hospital-acquired category three pressure ulcer	NA	All investigations are underway in line with the Trust-wide approved processes	
Incidents under investigation involving death of a patient	There were two incidents under investigation involving death of a patient; hospital-acquired Covid-19 infections after 14 days of admission	NA	Duty of candour has commenced for both events and investigations are underway.	
Incidents under investigation involving severe harm	There was one incident under investigation involving severe harm; maternity incident.	NA	No concerns have been identified during the initial review. The incident will be subject to a detailed review via the PMRT process and any learning will be shared with staff and the family.	



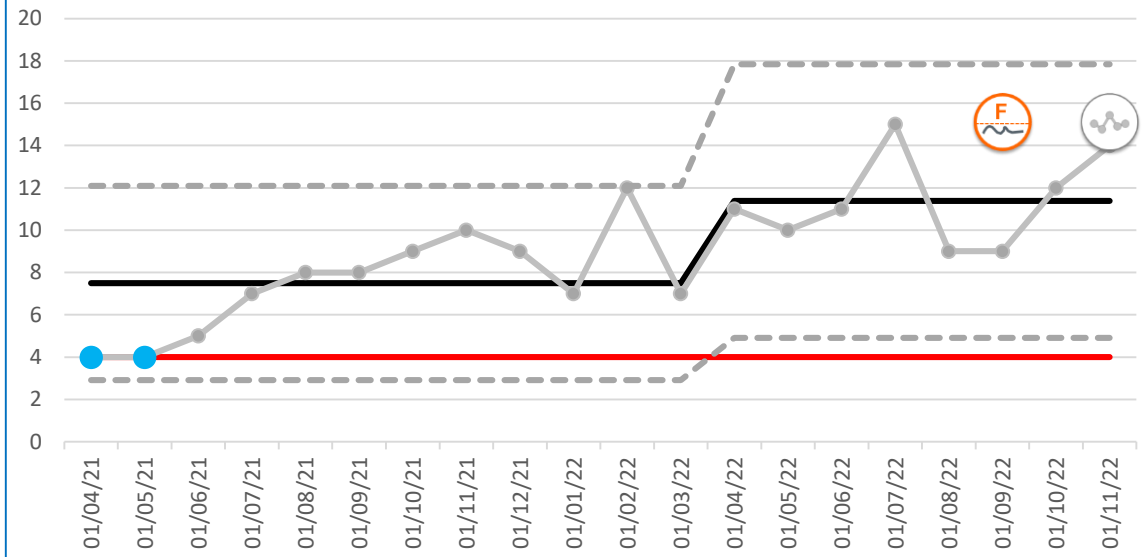


December 2022	Target	Variance Type
108	65	Common cause variation, no significant change.This process is not capable. It will FAIL to meet target without process redesign.

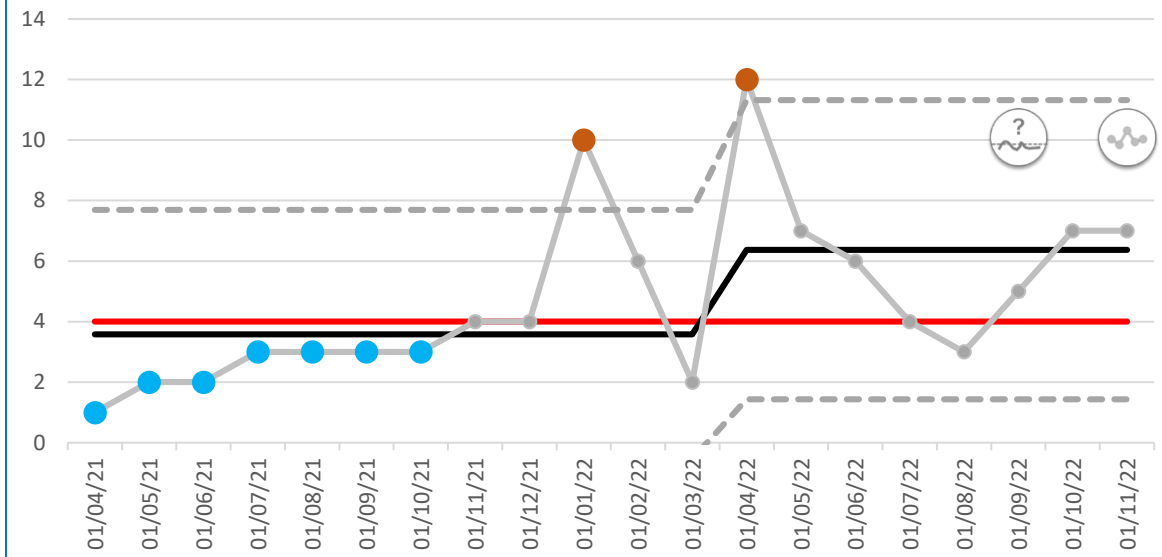
December 2022	Target	Variance Type
0	15	Common cause variation, no significant change. The system will consistently PASS.

Background	What the chart tells us:	Issues	Actions	Context
Inpatient Falls	The number of falls is average and within normal variation. All wards are within normal variation. Three ward areas to note – Ward 17 below average, DCU on the upper control limit, Ward 34 above average No harmful falls reported in December.	Additional patients on ward areas (1 or 2 additional patients), DCU opened overnight, additional patients on ward 34 and orthopaedic elective surgery stopped late December to accommodate medical inpatients .	Extended visiting on 2 surgical wards. Task and finish group to review enhanced care across the Trust. Review individual areas SPC charts and support any variation with Falls Practitioner.	

Pressure Ulcers category 2 (Lapses in care)



Pressure Ulcers category deep tissue Injury

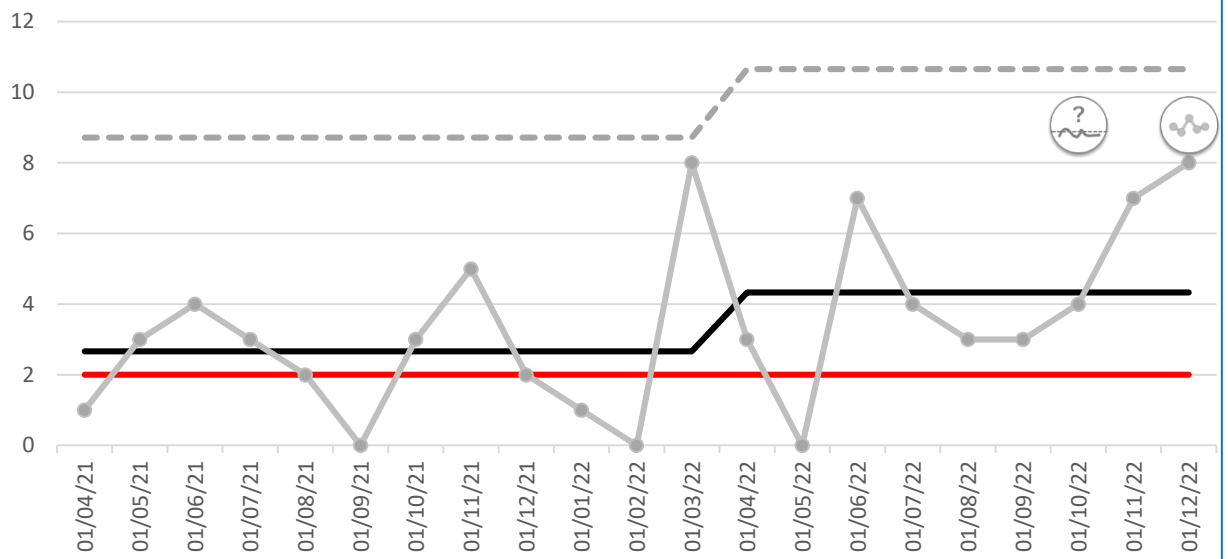


November 2022	Target	Variance Type
14	4	Common cause variation, no significant change.This process is not capable. It will FAIL to meet target without process redesign.

November 2022	Target	Variance Type
7	4	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

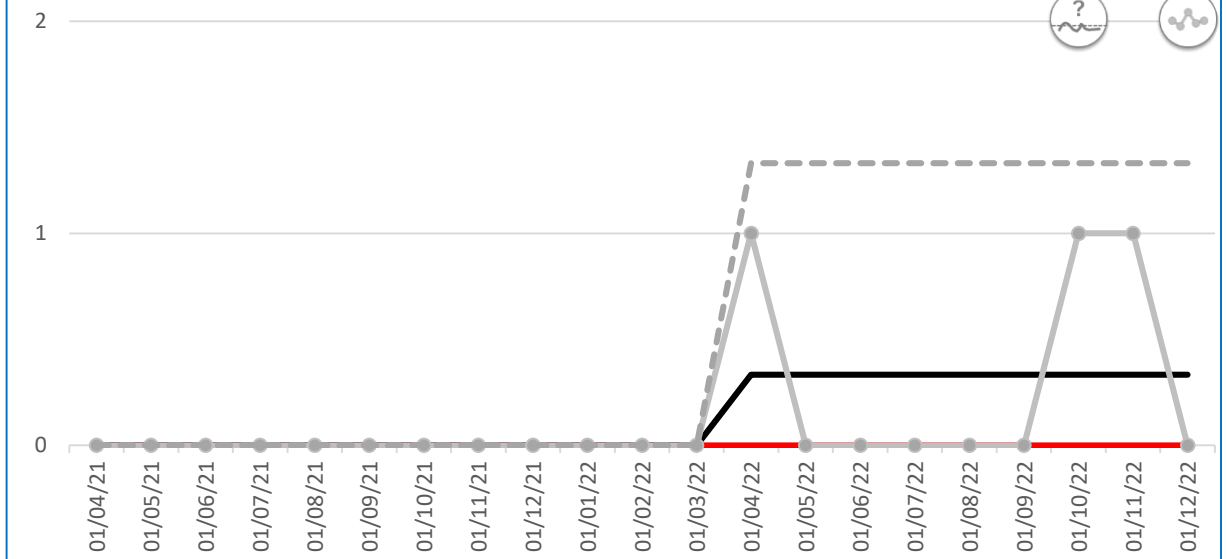
Background	What the chart tells us:	Issues	Actions	Context
Pressure Ulcers	The HA C2s with lapses continues to increase as do DTI. However the number of reported pressure ulcers has also increased for the month. Ward 30 has had a spike in their SPC however multiple pressure ulcers developed on the same patient, causing the rise.	Patient acuity. Staff shortages – Ward 30 in particular running with a lot of NHSP and high levels of enhanced care patients.	TVN has worked on Ward 30 to help with education at the bedside whilst helping with patient care.	

Q - Hospital Acquired Clostridioides difficile



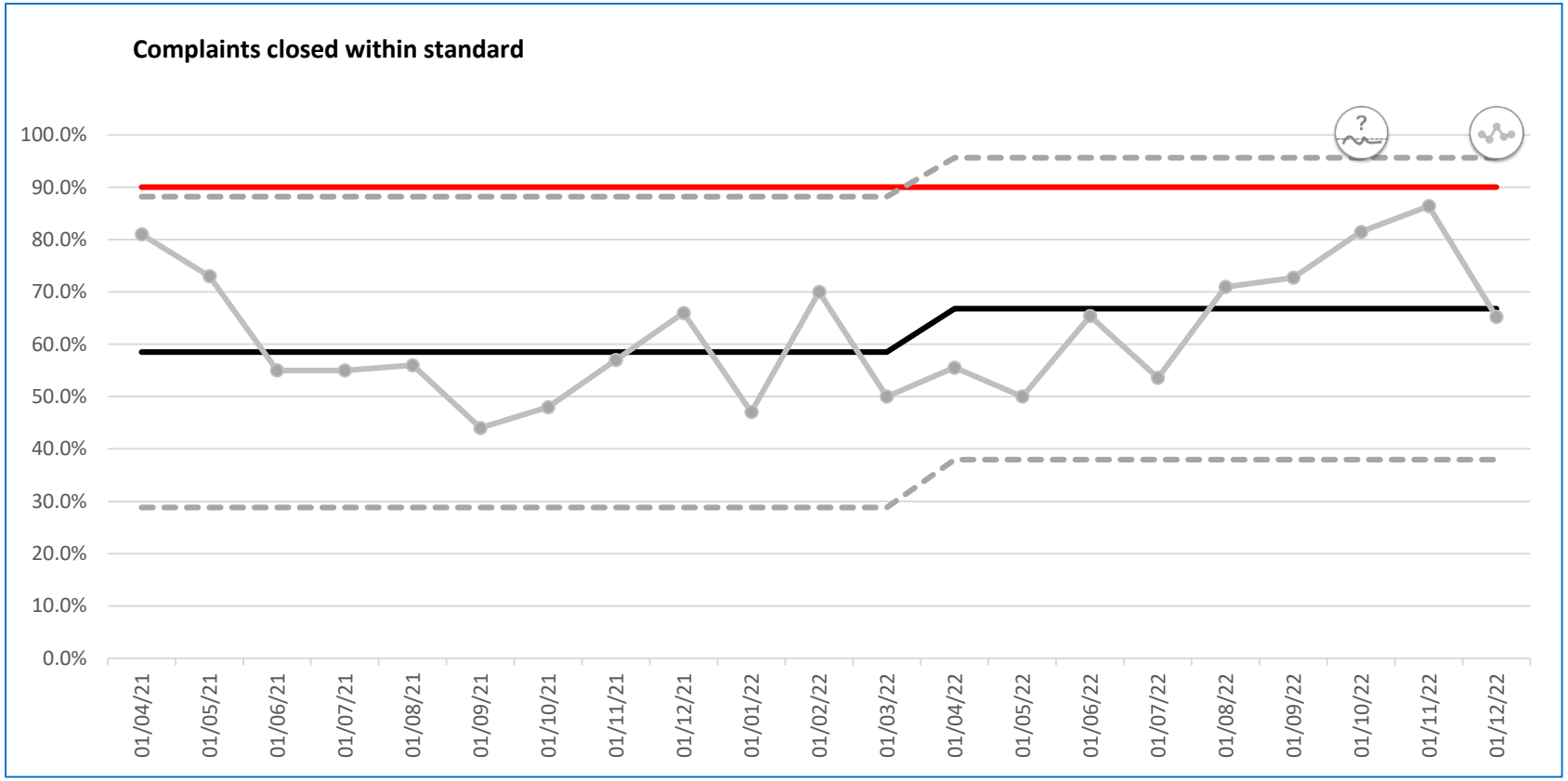
December 2022	Target	Variance Type
8	2	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Q- Hospital Acquired MRSA Bacteraemia



December 2022	Target	Variance Type
0	0	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Context
Infections			Of the eight cases, a root cause analysis and MDT has been undertaken on one case. The infection was felt to be unavoidable. Lessons were identified relating to a lack of clinical samples to support the continuation of antibiotics. The eight cases were identified in different clinical areas with no trends identified in potential exposure from other wards.	



December 2022

65.2%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

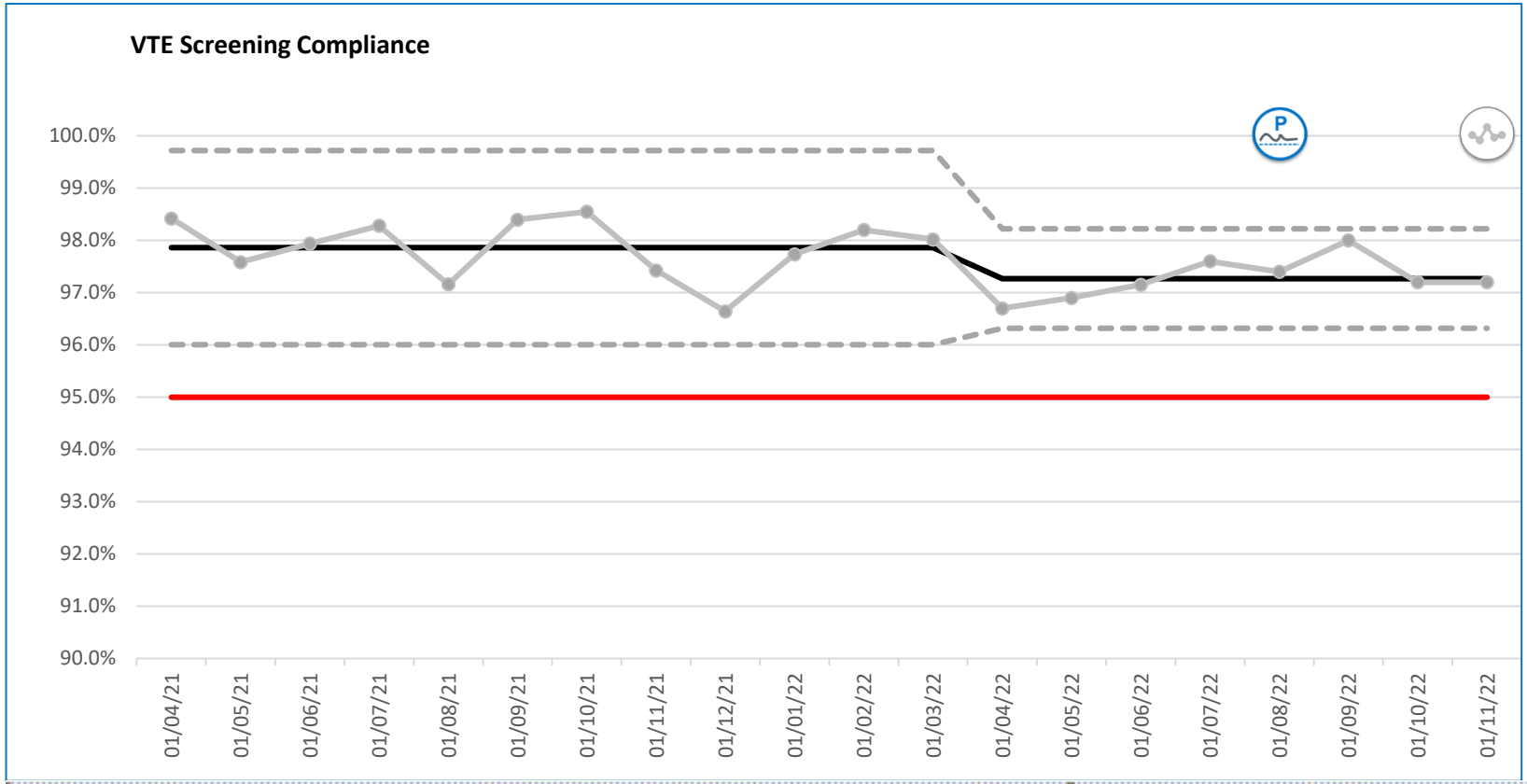
Target

90%

Target Achievement

Measure is failing the target.

Background	What the chart Tells Us	Issues	Actions	Context
Complaints closed within local standard	Consistently failing to achieve the KPI of responding to all formal complaints within 40 working days. This has decreased this month, with 65% closed within target but averages of 36 working days.	* Increased number of formal complaints being received by the Trust which are also increased in complexity * Delays in obtaining information and statements required to respond to formal complaints * External agencies in joint investigations working to longer timeframes	* Weekly email escalation processes in place to support the timely access to information and statements required to respond to formal complaints. * Weekly face to face meeting with CBU triumvirates and Complaints Manager * Weekly exception reports to the DoN&Q and MD as required * Escalations at CBU performance meetings * Have engaged with QI team and process mapping is planned to identify any areas where time can be recouped/improvements can be made.	Processes are in place to maintain contact with all complainants with regards to progress of formal complaint investigations.



November 2022

97.2%

Variance Type

Common cause variation, no significant change. The system will consistently PASS.

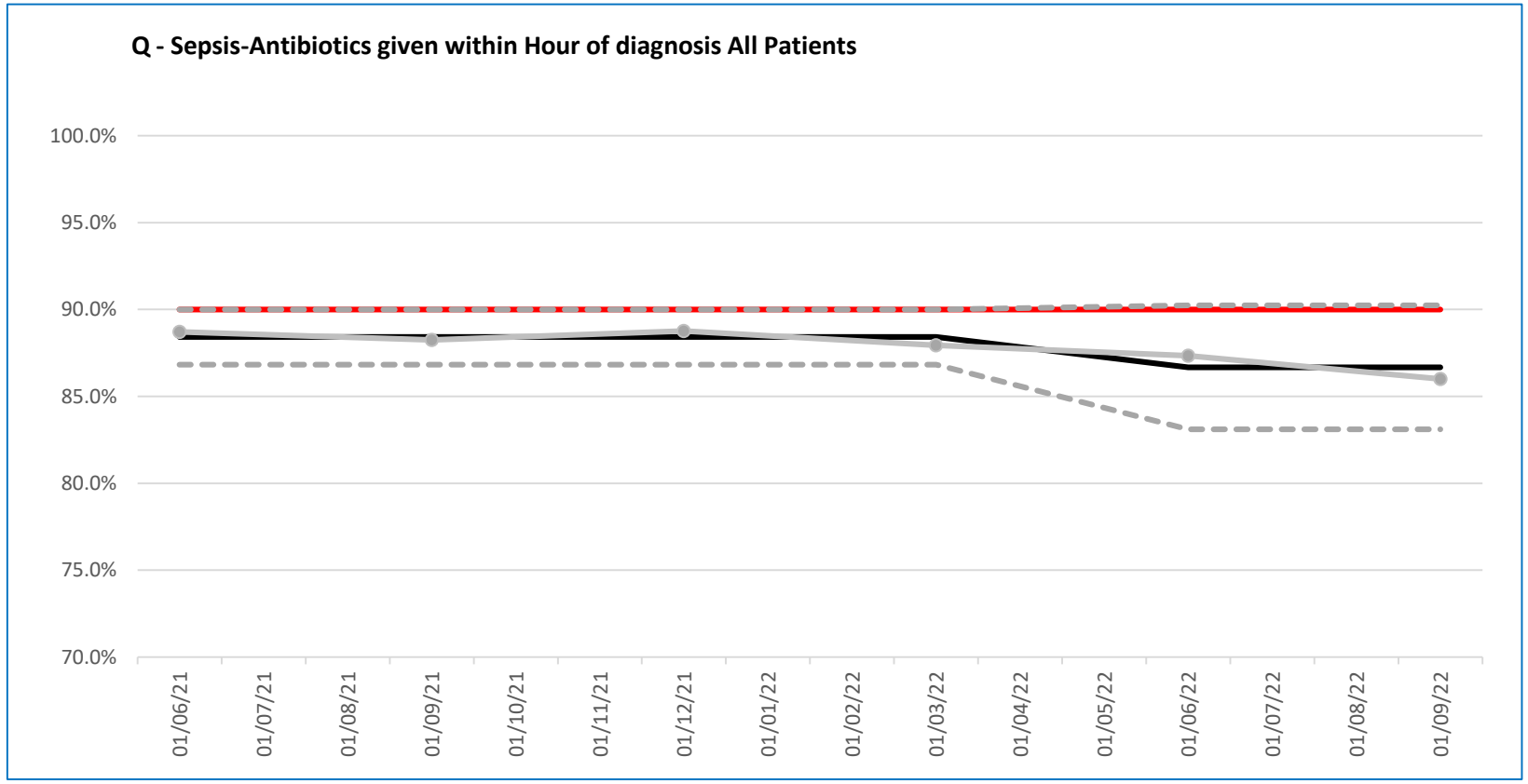
Target

95%

Target Achievement

Consistently passing target.

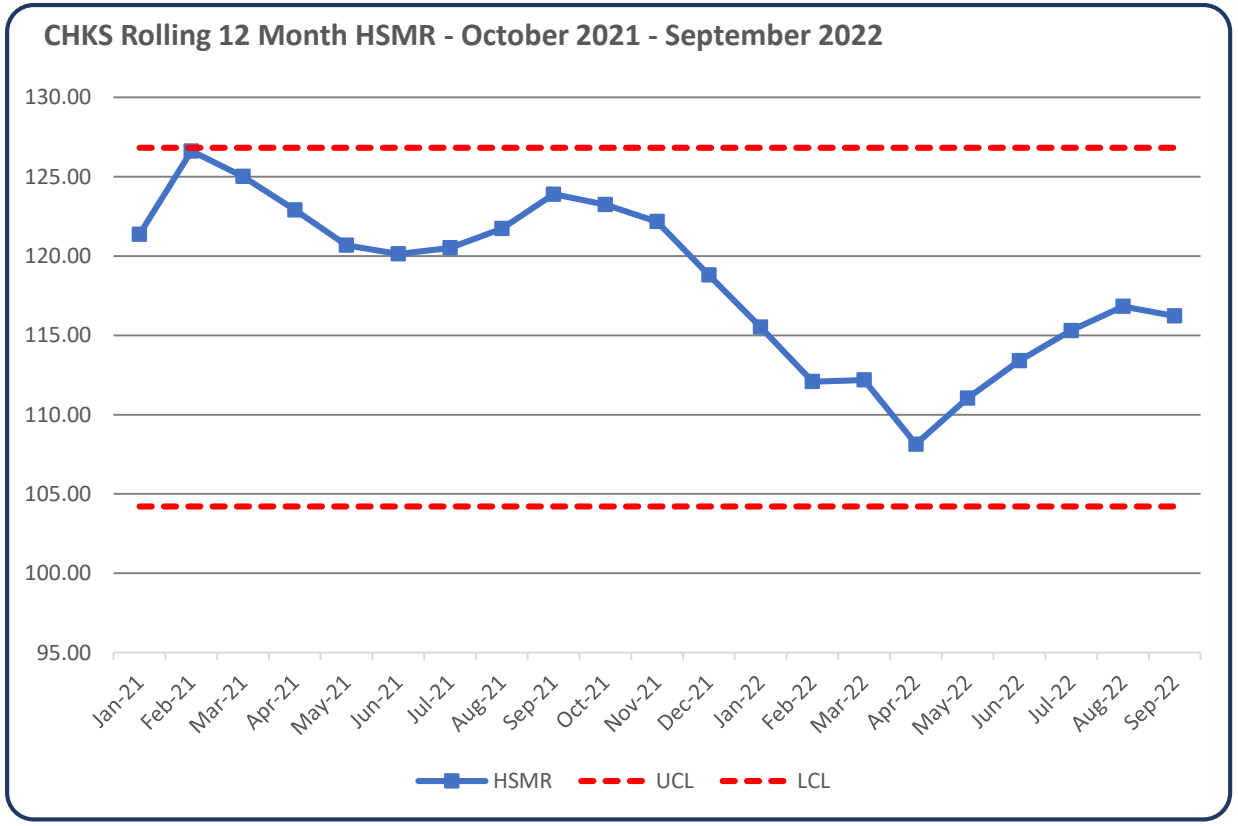
Background	What the chart tells us	Issues	Actions	Context
VTE Screening Compliance is a National Quality Requirement in the NHS Standard Contract 2022/23	The target is consistently being achieved	Ensuring all data sources are included - specialities and their individual performance can be viewed on iRIS	The clinical teams that have not achieved the target have been informed and support offered	Annual update of the data specification which informs reporting Manual sample validation checks take place each month.



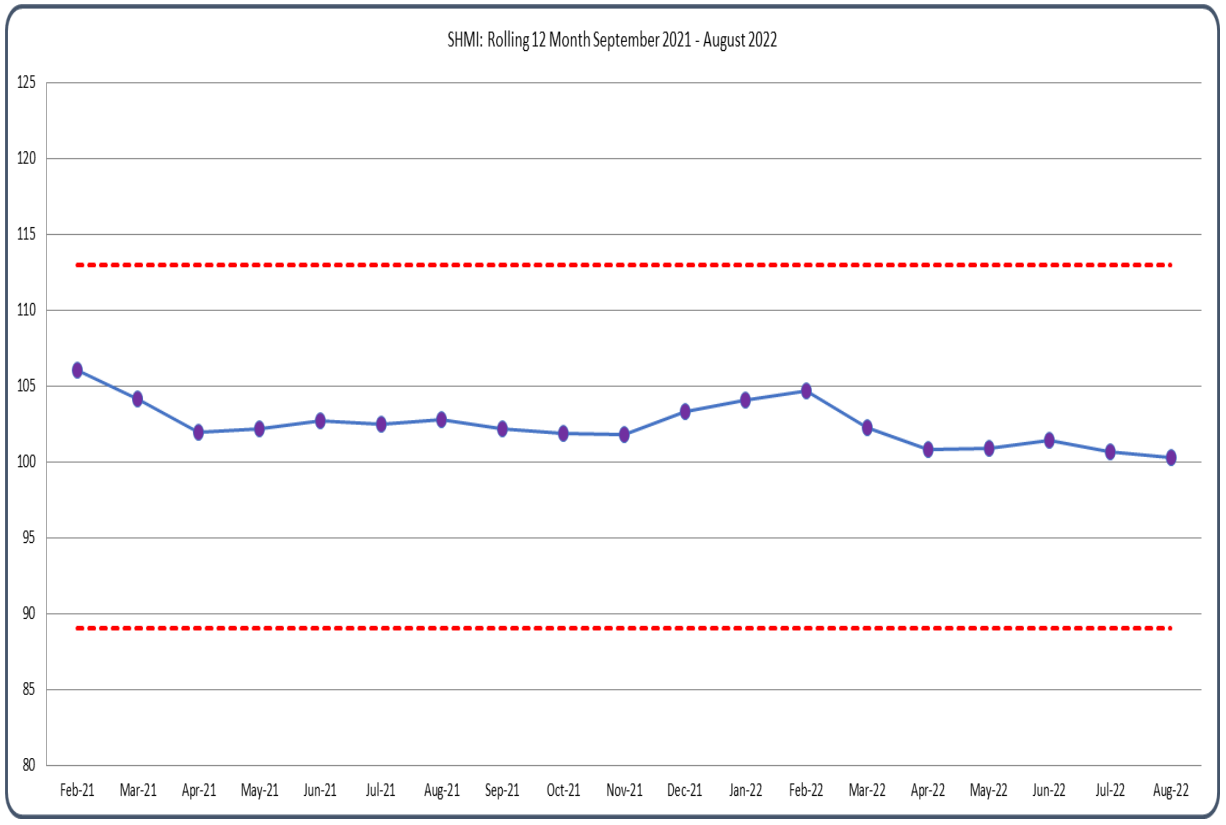
Q2 2022/23
86.0%
Variance Type
Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)
Target
90%
Target Achievement
Will hit and miss the target.

Background	What the chart tells us	Issues	Actions	Context
Sepsis is a National Quality Requirement in the NHS Standard Contract 2022/23	The target for inpatients is consistently met ED has not met the target for within the hour	ED sepsis is on the risk register	ED own the improvement workstream	Patients with sepsis coded in the Primary, 1st & 2nd position are checked by the clinical lead for sepsis for accuracy and learning

HSMR



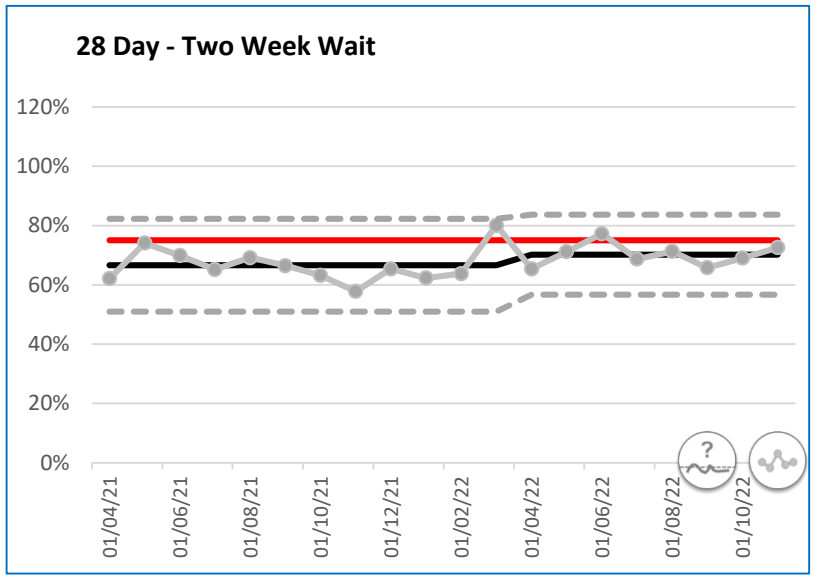
SHMI

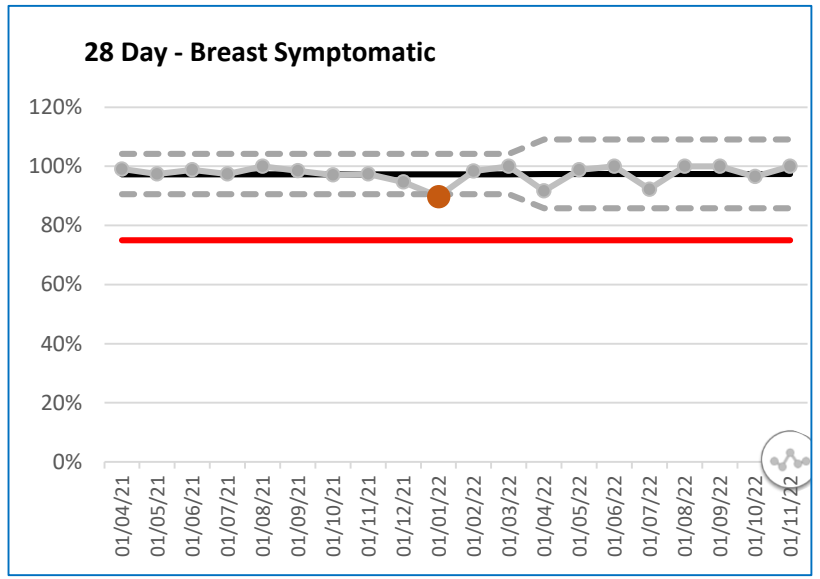


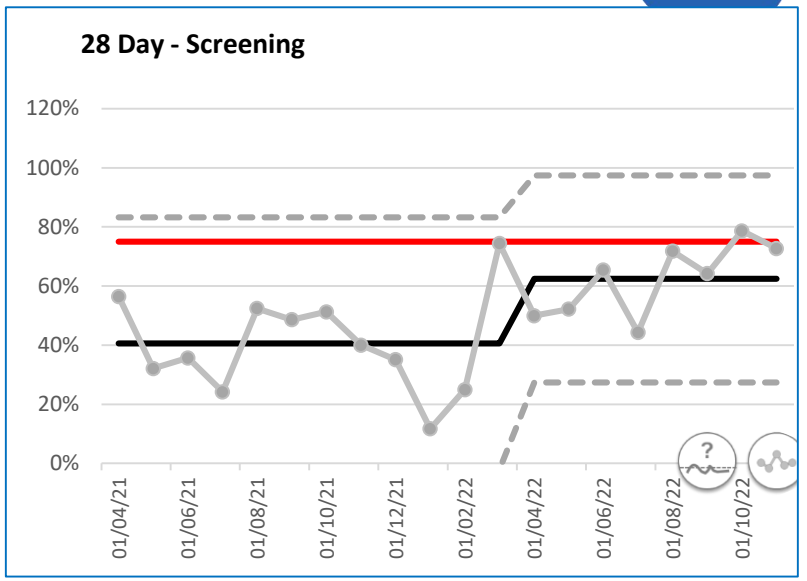
Commentary

HSMR Rolling 12 Month – October 2021 – September 2022 **116.22**

SHMI Latest reporting period – September 2021 – August 2022 **100.30**







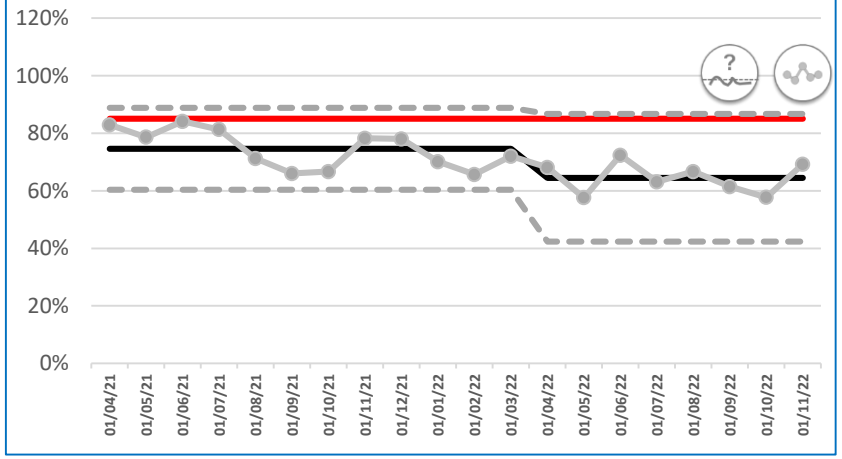
November 2022	Target	Variance Type
73%	93%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

November 2022	Target	Variance Type
100%	93%	Common cause variation, no significant change. The system will consistently PASS.

November 2022	Target	Variance Type
73%	96%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

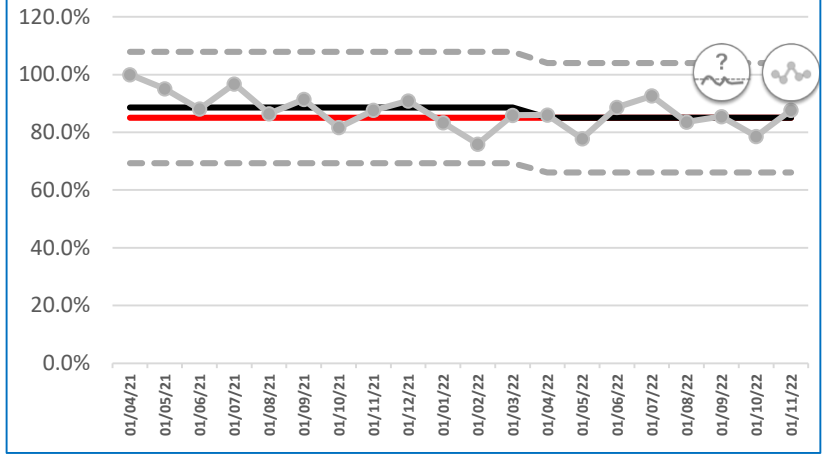
Background	What the chart tells us	Issues	Actions	Context
Cancer - 28 Days • **2 Weeks Waits** • **Breast Symptomatic** • **Screening**	Performance is variable and may hit or miss the target	Surge in referrals for specific tumour sites. Workforce gaps, specifically radiology & histopathology.	Trust achieved 95% appointments within 2 weeks in Nov 2022 Breast symptomatic 1st appt slightly below target but pathway catches up due to 1 stop clinics. Introduction of navigator roles. Review of booking processes. Diagnostic slots to enable test before 1st appointment.	2 week wait 27/136 providers. 28 day standard – 55/136 providers. Booking processes changed to drive 1st appt within 7 days.

62 Day - Urgent GP Referral to Treatment



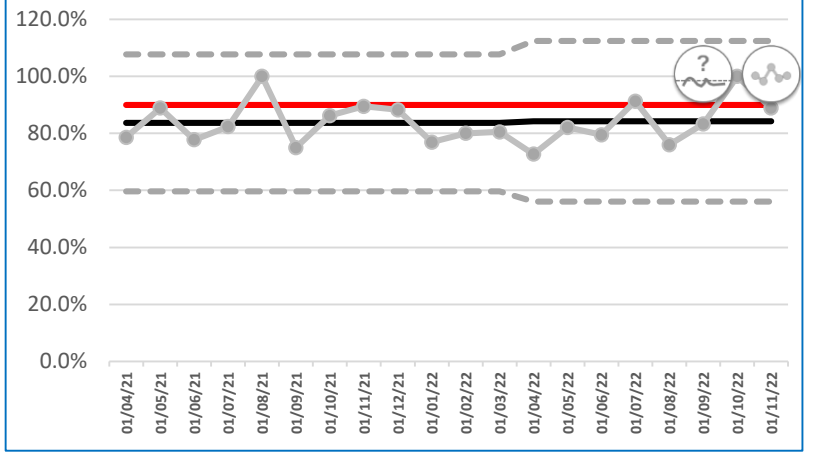
November 2022	Target	Variance Type
69%	85%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

62 Day - Consultant Upgrades



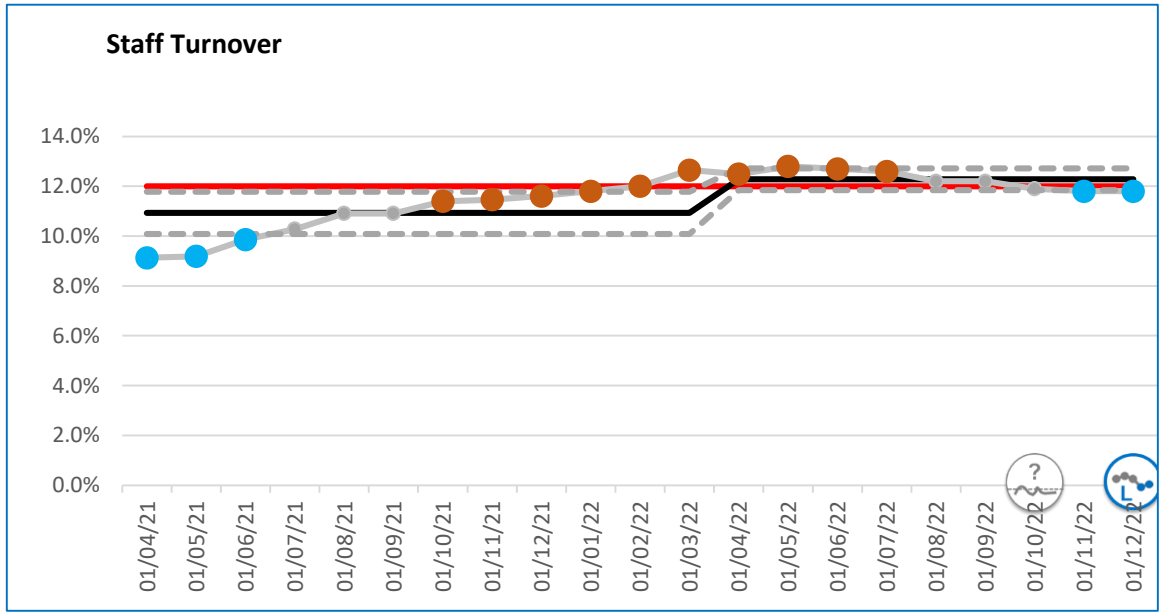
November 2022	Target	Variance Type
88%	85%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

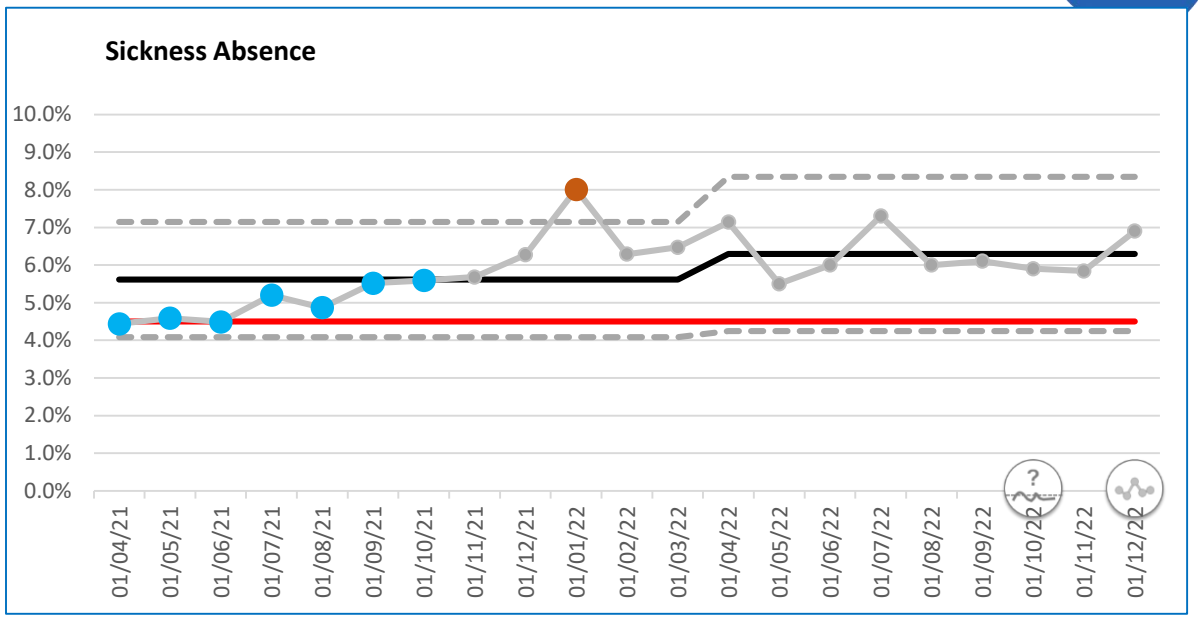
62 Day - Screening Programme



November 2022	Target	Variance Type
89%	90%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Background	What the chart tells us	Issues	Actions	Context
Cancer • **62 Day Urgent GP Referral** • **62 Day Screening Programme** • **62 Day Consultant Upgrades**	Performance is below target and continues to be at the lower control level.	Surge in referrals for specific tumour sites. Gaps in workforce. Capacity across tertiary centres. Complex presentations & morbidity. Suspension of activity in April 2020. Treating patients > 62 days increases monthly breach numbers.	Diagnose & treat all long waiting patients. Review pathways with tertiary centres. SYB Cancer Alliance work programme 2022/2023. Robust escalation process. Continued focus on long waiting patients required prior to any target improvement. Developing improvement plans for Urology & LGI.	Reducing > 62 day patients – stretch target of 25 by March 2023. 62 days 51/134. High level of clinical engagement across all tumour sites. 62 day referral to treatment national benchmark – 73/135.





December 2022	Target	Variance Type
11.8%	**10% - 12%**	Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

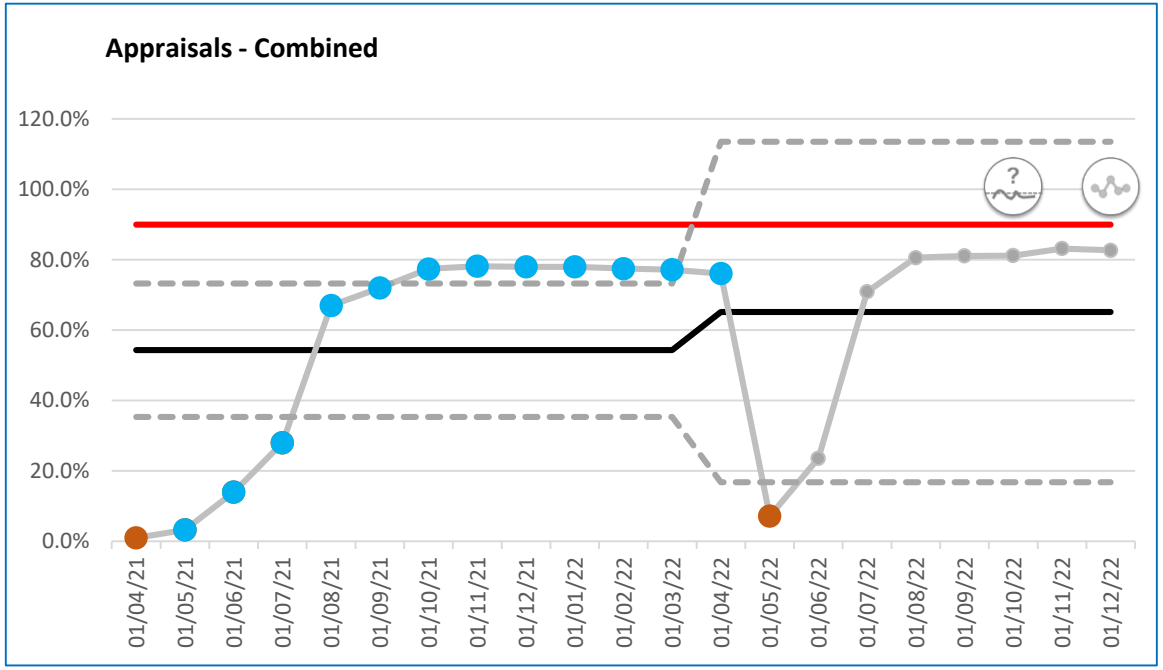
Staff Turnover

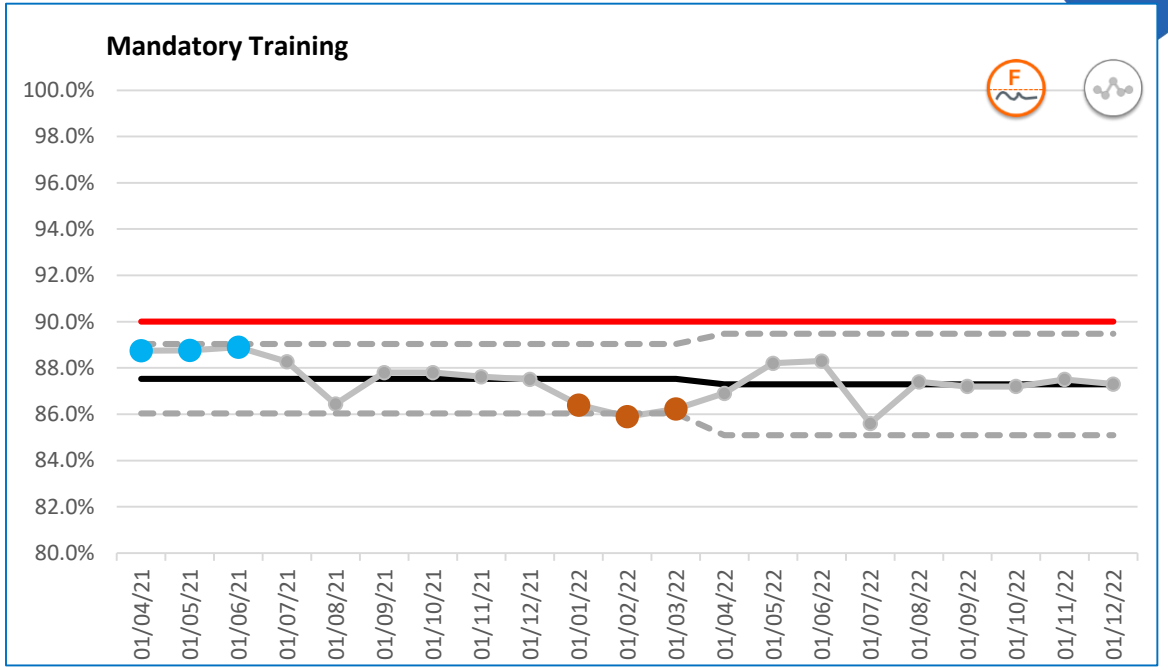
Issues	Continued low uptake of exit interview questionnaires.
Actions	New SY ICS retention network meeting monthly to share organisational action plans and develop community of practice, including shared learning on trialling new exit survey systems and processes to improve uptake.
Context	Staff turnover remains under 12% for third consecutive month. The Trust compares favourably to the ICS and nationally and is within the 1st quartile of turnover for nurses, AHPs and support to nurses (Model Hospital data Sept 2022).

December 2022	Target	Variance Type
6.9%	**4.5%**	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Sickness Absence

Issues	Continued low completion of return to work interviews. Mental health related sickness remains the top reason for absence which reflects the regional and national picture.
Actions	RTW information sent out weekly to CBU leads to target and discuss at Business & Governance meeting. Additional RMN commencing Occupational Health post this month and occupational psychologist recruited to join OH team in February/March 2023. 50 HWB Champions and 17 FTSU Champions recruited. As at 22nd December 2022, 50% of staff have received the Covid booster vaccination and 50% of staff are vaccinated for influenza.
Context	The number of long term sickness episodes is starting to improve. Trust sickness absence performance is 4th out of 7 trusts in the ICS, where average absence rate is 6.39% compared to Trust rate of 6.4% (Oct 2022).





December 2022	Target	Variance Type
82.7%	**90%**	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

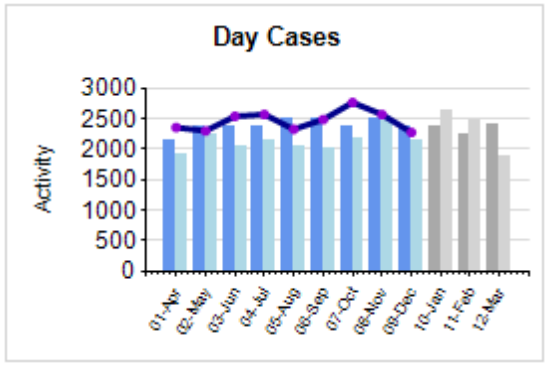
Appraisals – Combined	
Issues	Continued operational pressures may affect compliance in certain areas.
Actions	Development of new CBU workforce performance dashboards at departmental level available on a quarterly basis in progress.
Context	Data indicates there has been sustained improvement in appraisal activity.

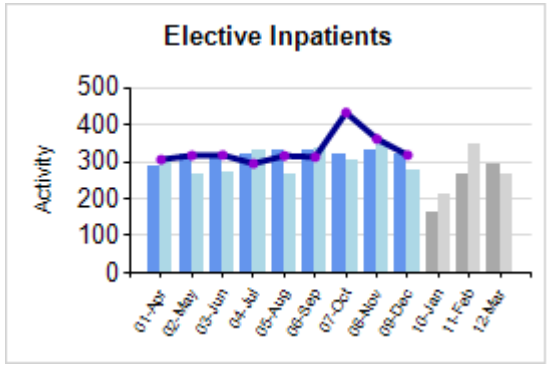
December 2022	Target	Variance Type
87.3%	**90%**	Common cause variation no significant change. This system is not reliably capable and it will FAIL the target without system change

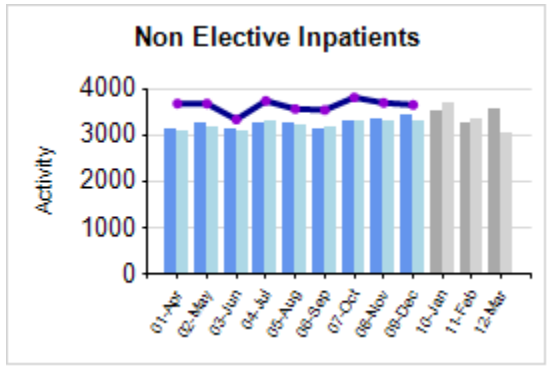
Mandatory Training	
Issues	Mandatory training overall compliance has remained reasonably static.
Actions	The introduction of Datix reporting for non- attendance of safeguarding and resus training has reduced DNAs from an average of 74 per month (between April – Oct) to 21 in Dec.
Context	Improvement in safeguarding training compliance level 1 at 91%, level 2 at 80% and in Resus training at 78% - 80%. All mandatory training topics are in amber or green for compliance.

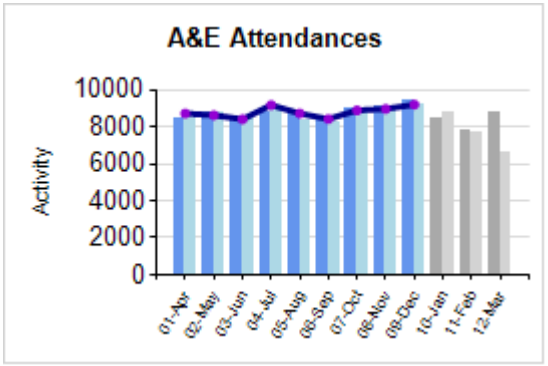
2022/23 Year to Date Activity

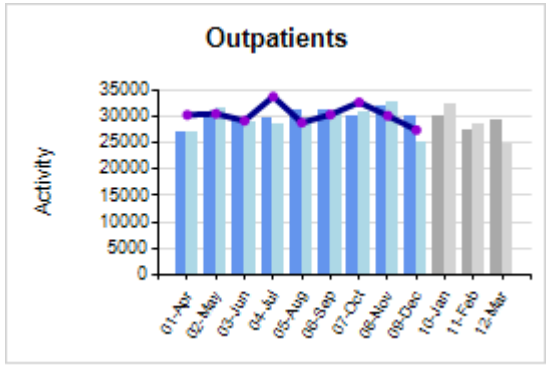
	19/20 Actuals	2022/23 Plan	2022/23 Actuals	Variance	%
Elective Daycases	22,185	21,568	19,247	(2,321)	-11%
Elective Inpatients	2,978	2,869	2,701	(168)	-6%
Elective Total	**25,163**	**24,437**	**21,948**	**(2,489)**	**-10%**
Non Elective	32,713	29,163	28,892	(271)	-1%
Non Elective Total	**32,713**	**29,163**	**28,892**	**(271)**	**-1%**
Maternity Pathway	4,842	4,425	4,269	(156)	-4%
Maternity Pathway Total	**4,842**	**4,425**	**4,269**	**(156)**	**-4%**
A&E Att.	79,154	79,416	78,213	(1,203)	-2%
A&E Total	**79,154**	**79,416**	**78,213**	**(1,203)**	**-2%**
Outpatients	272,884	269,118	264,745	(4,373)	-2%
Outpatients Total	**272,884**	**269,118**	**264,745**	**(4,373)**	**-2%**











Commentary

The activity breakdown below is a YTD position based on April – December 2022.

- Day Case = 86.7%
- Elective inpatient = 93.7%
- Outpatients (1st) = 83.9%
- Overall position = 84.48%

There have been some changes in local pathways and how activity is recorded since 2019/2020. For instance, in 2019/2020 1st OP activity flowed for A&E and the children's assessment unit (CAU) – this alone represents approx. 4% of the YTD shortfall.

In addition, the recording of clinical activity has appropriately changed for some services since 2019/2020, which will impact the overall ERF comparisons to that period – examples include flexi-cystoscopies were previously recorded as a day case activity, they are now recorded as an outpatient attendance and the change in pathway within T&O and injections - this has a material impact on the Trusts ability to achieve 2019/2020 levels. Further work is being undertaken to quantify this in more detail.

Performance Matters - Finance

Dec 22 Summary

RAG Rating Summary Performance:		
Finance	**Planned Financial Position**	As at month 9 the Trust has a consolidated year to date deficit of £3.217m against a planned deficit of £5.674m giving a favourable variance of £2.457m. NHS England and Improvement (NHSE/I) adjusted financial performance after taking into account income and depreciation in respect of donated assets £0.062m and granted assets (£1.414m), is a deficit of £4.569m with a favourable variance of £1.105m. Forecast most likely case remains a £5.2m deficit which continues to give a NHSE/I adjusted forecast of £8.8m deficit consistent with plan and last month's forecast; with a NHSE/I best case £4.1m deficit and worst case £9.8m deficit.
	Underlying Financial Position	The Trust are posting an NHSE/I adjusted financial performance deficit of £4.569m, however, there are several non-recurrent costs and benefits within this position which mask the true underlying performance. Adjusting for all of these would result in a "real" position of £11.547m deficit.
	Income	Total income is £3.950m favourable to plan for the year. The majority of clinical income is subject to block arrangements and system allocations. The favourable variance is mainly due to higher than expected recharges and training & education income, along with grant income in respect of the capital decarbonisation scheme; partly offset by providing for a potential income clawback risk.
	Planned Cash Position	Cash balances have decreased from last month by £3.329m, although the year to date favourable variance against plan has decreased by £0.986m which is mainly due to timings of payments to creditors, slippage on the capital programme and receipt of NHS income.
	Capital Plan	Capital expenditure for the year is £5.472m, which is £0.805m below plan. The underspend is mainly due to slippage on estates and IT schemes which are expected to recover during the year.

The RAG rating applied to Variance % is based on the following criteria:

- **Green equating to 0% or greater**
- **Amber behind plan by up to 5%**
- **Red greater than 5% behind plan**

Finance Performance

Dec 22 Summary

	Performance - Financial Overview								Variance Analysis							
	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %	Electives	Urgent Care	ERF	Covid	Efficiency	Recharges	Run Rate & NR Flex	Total
ACTIVITY LEVELS (PROVISIONAL)																
Elective inpatients	317	274	(43)	-13.56%	2,869	2,701	(168)	-5.86%	(168)							(168)
Day cases	2,384	2,142	(242)	-10.15%	21,568	19,247	(2,321)	-10.76%	(2,321)							(2,321)
Outpatients	27,589	23,192	(4,397)	-15.94%	249,611	241,770	(7,841)	-3.14%	(7,841)							(7,841)
Non-elective inpatients	3,440	3,283	(157)	-4.56%	29,194	28,908	(286)	-0.98%		(286)						(286)
A&E	9,445	9,193	(252)	-2.67%	79,416	78,213	(1,203)	-1.51%		(1,203)						(1,203)
Other (excludes direct access tests)	9,522	11,060	1,538	16.15%	88,258	114,383	26,125	29.60%							26,125	26,125
Total activity	**52,697**	**49,144**	**(3,553)**	**-6.74%**	**470,916**	**485,222**	**14,306**	**3.04%**	**(10,330)**	**(1,489)**	**0**	**0**	**0**	**0**	**26,125**	**14,306**
INCOME	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Elective inpatients	966	775	(191)	-19.77%	9,117	8,538	(579)	-6.35%	(579)							(579)
Day Cases	1,598	1,552	(46)	-2.88%	15,087	14,214	(873)	-5.79%	(873)							(873)
Outpatients	3,116	2,426	(690)	-22.14%	29,342	25,961	(3,381)	-11.52%	(3,381)							(3,381)
Non-elective inpatients	7,994	7,683	(311)	-3.89%	70,380	68,552	(1,828)	-2.60%		(1,828)						(1,828)
A&E	1,511	1,431	(80)	-5.29%	13,390	13,137	(253)	-1.89%		(253)						(253)
Other Clinical	4,633	6,647	2,014	43.47%	42,426	49,719	7,293	17.19%	4,833	2,081					380	7,293
Top-up, Covid and ERF	2,524	2,554	30	1.19%	23,079	23,354	275	1.19%				275			0	275
Other	1,663	1,937	274	16.48%	14,836	18,132	3,296	22.22%	(1,821)				726	3,444	946	3,296
Total income	**24,005**	**25,005**	**1,000**	**4.17%**	**217,657**	**221,607**	**3,950**	**1.81%**	**(1,821)**	**0**	**0**	**275**	**726**	**3,444**	**1,326**	**3,950**
OPERATING COSTS	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Pay	(17,482)	(18,913)	(1,431)	-8.19%	(156,574)	(161,093)	(4,519)	-2.89%	3,274	167	2,694	(1,689)	(4,305)	(3,414)	(1,246)	(4,519)
Drugs	(1,531)	(1,596)	(65)	-4.25%	(13,212)	(13,848)	(636)	-4.81%	276	14	513		61	(46)	(1,454)	(636)
Non-Pay	(5,213)	(4,590)	623	11.95%	(46,123)	(43,124)	2,999	6.50%	409	49	2,517	(244)	(660)	16	912	2,999
Total Costs	**(24,226)**	**(25,099)**	**(873)**	**-3.60%**	**(215,909)**	**(218,065)**	**(2,156)**	**-1.00%**	**3,959**	**230**	**5,724**	**(1,933)**	**(4,904)**	**(3,444)**	**(1,788)**	**(2,156)**
EBITDA	**(221)**	**(94)**	**127**	57.47%	**1,748**	**3,542**	**1,794**	102.63%	**2,138**	**230**	**5,724**	**(1,658)**	**(4,179)**	**0**	**(461)**	**1,794**
Depreciation	(571)	(376)	195	34.15%	(5,454)	(5,258)	196	3.59%							196	196
Non Operating Expenditure	(210)	(107)	103	49.05%	(1,968)	(1,501)	467	23.73%					449		18	467
Surplus / (Deficit)	**(1,002)**	**(577)**	**425**	42.42%	**(5,674)**	**(3,217)**	**2,457**	43.30%	**2,138**	**230**	**5,724**	**(1,658)**	**(3,730)**	**0**	**(247)**	**2,457**
NHSE/I adjusted financial performance	**(1,002)**	**(956)**	46	4.59%	**(5,674)**	**(4,569)**	1,105	19.47%								

Finance Performance

Commentary

The key points derived from this table are as follows:

- The final plan approved by the Board of Directors and submitted in June was an £8.8m deficit, in the context of a South Yorkshire (SY) system balanced plan.
- The block arrangements, introduced by NHS England and Improvement (NHSE/I) at the start of 2020/21, continue in 2022/23.
- As at month 9 the Trust has a consolidated year to date deficit of £3.217m against a planned deficit of £5.674m giving a favourable variance of £2.457m. NHS England and Improvement (NHSE/I) adjusted financial performance after taking into account income and depreciation in respect of donated assets £0.062m and granted assets (£1.414m), is a deficit of £4.569m with a favourable variance of £1.105m. The key drivers behind the variance are set out in the above table.
- The plan was set aligned to the national NHSE/I planning guidance, which assumed low levels of Covid and set a planned care recovery target of 104% weighted value of 2019/20 levels of planned care delivery, supported with Elective Recovery Fund (ERF) monies.
- The current context seen across the system has not been one of low levels of Covid in 2022/23, and planned care recovery is not at the aspirational levels that were set in the plan.
- The national average bed occupancy for Covid patients in quarter 1 2021/22 was 1%, and this level was assumed as the definition of "low levels of Covid" from a planning perspective. The reality seen in 2022/23 is c5% of beds being occupied by Covid positive patients.
- This has impacted directly on expenditure due to the costs required to manage Covid patients and increased staff absence, and also indirectly by hampering the ability to deliver efficiencies and the planned care recovery aspirations.
- Given the reality is very different to the planning guidance assumptions, NHSE/I have recently confirmed that the ERF income will not be clawed back, and instead will be retained by the system to cover the impacts of ongoing Covid demands.
- The cost increase as a result of Covid (£1.658m) plus the undelivered efficiency (£3.730m) is offset by the £5.724m retained ERF income. From a plan perspective the ERF income and cost (the 4% increase above 2019/20 core allocation levels) was assumed to be net neutral, therefore, given the non delivery of ERF activity the cost is not incurred, but the income is retained to offset the Covid impact.
- The plan also assumed recovery back to 100% of 2019/20 planned care activity levels within core ICB allocations, before the additional ERF requirement to 104%. Given actual planned care activity is c90% of 2019/20 levels there is inevitably a cost saving (£2.138m) from delivering less activity than plan. This is currently offsetting the remainder of the increased Covid impact, excess inflationary and other run rate pressures.
- In-month activity is 14.05% less than last month which is also 6.74% below plan for the month with only other above planned levels. However, the acuity of patients presenting at ED and requiring admission continues to be high, with higher than usual length of stay as a result.
- As at month 9 the Trust are posting an NHSE/I adjusted financial performance deficit of £4.569m, however, there are several non-recurrent costs and benefits within this position which mask the true underlying performance. Adjusting for all of these would result in a “real” position of £11.547m deficit.
- Forecast most likely case remains a £5.2m deficit which continues to give a NHSE/I adjusted forecast of £8.8m deficit consistent with plan and last month’s forecast; with a NHSE/I best case £4.1m deficit and worst case £9.8m deficit.

Finance Performance

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %	Commentary
Capital Programme	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		
Capital Spend - internally funded	(829)	(912)	(83)	-10.03%	(6,277)	(4,044)	2,233	35.57%	• Capital expenditure underspend is mainly due to slippage on estates and IT schemes which are expected to recover during the year. The externally funded expenditure is mainly on the grant funded decarbonisation scheme.
Capital Spend - externally funded	0	(622)	(622)		0	(1,428)	(1,428)		
Statement of Financial Position (SOFP)									
Inventory					1,931	2,342	(411)	21.28%	• Receivables are below plan due to the timing of receipts of NHS income and increased income risk provision.
Receivables					9,476	6,124	3,352	-35.37%	
Payables (includes accruals)					(28,498)	(42,554)	14,056	-49.32%	• Payables are above plan mainly due to timings of payments to creditors and accruals.
Other Net Liabilities					(4,175)	(8,136)	3,961	-94.87%	
Cash & Loan Funding					**£'000**	**£'000**	**£'000**		
Cash					13,598	37,851	24,253	178.36%	• Cash balances have decreased from last month by £0.553m, although the year to date favourable variance against plan has increased by £0.986m which is mainly due to timings of payments to creditors, slippage on the capital programme and receipt of NHS income.
Loan Funding					0	0	0		
Efficiency and Productivity Programme (EPP)	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		
Income	0	150	150		0	1,175	1,175		• The higher than expected levels of Covid seen so far this year have prevented the majority of the efficiency savings linked to productivity improvements, back to 2019/20 levels, being achieved. Plans are in place to maximise these opportunities as and when Covid levels allow. There has been some success in expenditure run rate improvement schemes, although more needs to be done to return to a more sustainable cost base.
Pay	1,031	372	(659)		9,277	4,972	(4,305)		
Non-Pay	352	298	(55)		3,168	2,569	(599)		
Total EPP	**1,383**	**820**	(563)		**12,445**	**8,715**	(3,730)		
KPIs									
EBITDA %	-0.92%	-0.38%	0.54%	59.17%	0.80%	1.60%	0.80%	99.02%	• Payable days have been calculated excluding accruals, because whilst accruals include certainties in respect of future payments, the timing of these payments is uncertain. Expenditure has been calculated as operating costs, less pay, add back lead units, agency, and capital.
Surplus / (Deficit) %	-4.17%	-2.31%	1.87%		-2.61%	-1.45%	1.16%		
Receivable Days					7.2	3.3	3.9	-53.67%	
Payable (excluding accruals) Days					21.7	36.7	15.0	68.89%	
Better Payment Practice Code (BPPC)									• The code requires all valid invoices to be paid by the due date or within 30 days of receipt of the invoice, whichever is later. Performance is below the target 95% of invoices, in terms of value and volume; but is a slight improvement on last month.
Number of invoices paid within target					95.0%	92.6%	-2.41%	-2.53%	
Value of invoices paid within target					95.0%	94.0%	-1.02%	-1.07%	

3.2. Trust Objectives 2022/23 Progress Report

For Assurance

Presented by Bob Kirton

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/3.2

SUBJECT:	**Trust Objectives 2022/23 Progress Report**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	√		*Assurance*	√
	For review	√		*Governance*	√
	For information	√		*Strategy*	√
PREPARED BY:	Gavin Brownett, Associate Director of Strategy and Planning				
SPONSORED BY:	Bob Kirton, Chief Delivery Officer and Deputy CEO				
PRESENTED BY:	Bob Kirton, Chief Delivery Officer and Deputy CEO				

STRATEGIC CONTEXT

Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2022. They were presented at: Council of Governors, Executive Team, Finance & Performance Committee, Quality & Governance Committee and Trust Board. As agreed, progress against the Trust Objectives will be reported to ET, Q&G, F&P and Trust Board on a quarterly basis.

EXECUTIVE SUMMARY

Since approval, the objectives have also been published through all of the usual communication channels including the intranet, internet, team brief and posters displayed across the Trust. The Trust Objectives were cascaded in good time for staff appraisals, to support conversations about the individual's role in achieving the Trust objectives.

This paper presents the 2022/23 Quarter 3 progress update. Overall the Trust has progressed well with the objectives there are however some challenges and risks but mitigation plans have been implemented where possible and necessary.

Key Highlights: Good work across The Trust's support to a caring and supporting culture including the Equality, Diversity and Inclusion agenda has taken place. The Trust has now hit the annual target to recruit further Professional Nurse Advocates and Freedom to Speak Up champions and early indication of some positive themes from the staff survey. Delivery of the Decarbonisation (Salix) capital scheme is well underway with the installation of Air Source Heat Pumps (ASHP) expected by end of the financial year and transformer upgrade scheduled to take place January 2023.

Key Concerns: Formal complaints regarding communication & failings in compassionate care continue to increase and are not reducing in line with ambitions set out however turnaround time and quality of complainant responses has greatly improved and on reflection given the post pandemic affects and on-going challenges a reduction in complaints was unlikely in 2022/23. Whilst positive actions are being taken performance against urgent care, whilst better than many Trusts, is not improving as expected and quarter 3 has seen a deterioration in performance across the UEC pathways due to the significant operational pressures seen due to an increased in acuity and demand caused by respiratory and Covid illness.

Following a discussion at the Finance & Performance Committee last quarter there has been a particular focus on RAG rating consistency across the report. Upon further scrutiny at Quality and

Governance Committee in January a recommendation was made to remove two KPIs related to the quality priorities. Customer care training numbers are not measurable as the course was not reinstated post pandemic and upon reflection, a reduction in complaints given the post pandemic effects and on-going challenges was unlikely in 2022/23. With this in mind the Board of Directors are asked to consider the removal of these particular metrics.

Progress will continue to be monitored and reported on a quarterly basis.

RECOMMENDATIONS

The Board of Directors is asked to:

1. review and approve the report
2. accept this report as assurance of progress against the Trust Objectives.
3. consider the removal of KPIs related to customer care training and complaints reduction.

Subject:	2022-23 TRUST OBJECTIVES Q3 REPORT	Ref:	BoD: 23/02/02/3.2

1. STRATEGIC CONTEXT

1.1 Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2022. They were presented at: Council of Governors, Executive Team, Finance & Performance Committee, Quality & Governance Committee and Trust Board. As agreed, progress against the Trust Objectives will be reported to ET, Q&G, F&P and Trust Board on a quarterly basis.

2. INTRODUCTION

2.1 The Since approval, the objectives have also been published through all of the usual communication channels including the intranet, internet, team brief and posters displayed across the Trust. The Trust Objectives were cascaded in good time for staff appraisals, to support conversations about the individual's role in achieving the Trust objectives.

2.2 This paper presents the 2022/23 Quarter 3 progress update. Overall the Trust has progressed well with the objectives there are however some challenges and risks but mitigation plans have been implemented where possible and necessary.

2.3 Following a discussion at the Finance & Performance Committee last quarter there has been a particular focus on RAG rating consistency across the report. Upon further scrutiny at Quality and Governance Committee in January a recommendation was made to remove two KPIs related to the quality priorities. Customer care training numbers are not measurable as the course was not reinstated post pandemic and upon reflection a reduction in complaints given the post pandemic affects and on-going challenges was unlikely in 2022/23. With this in mind the Board of Directors are asked to consider the removal of these particular metrics.

3. KEY HIGHLIGHTS

3.1 Fantastic work across The Trust's support to a caring and supporting culture including the Equality, Diversity and Inclusion agenda has taken place. The Trust has now hit the annual target to recruit further Professional Nurse Advocates and Freedom to Speak Up champions and early indication of some positive themes from the staff survey.

3.2 Delivery of the Decarbonisation (Salix) capital scheme is well underway with the installation of Air Source Heat Pumps (ASHP) expected by end of the financial year and transformer upgrade scheduled to take place January 2023.

4. KEY CONCERNS

4.1 Formal complaints regarding communication & failings in compassionate care continue to increase and are not reducing in line with ambitions set out however turnaround time and quality of complainant responses has greatly improved and on reflection given the post pandemic affects and on-going challenges a reduction in complaints was unlikely in 2022/23.

4.2 Whilst positive actions are being taken performance against urgent care, whilst better than many Trusts, is not improving as expected and quarter 3 has seen a deterioration in performance across the UEC pathways due to the significant operational pressures

seen due to an increased in acuity and demand caused by respiratory and Covid illness.

5. RECOMMENDATIONS

5.1 The Board of Directors review and approve the report

5.2 The Board of Directors accept this report as assurance of progress against the Trust Objectives.

5.3 The Board of Directors considers the removal of KPIs related to customer care training and complaints reduction.

6. CONCLUSION

6.1 Overall the Trust has progressed well with the objectives there are however some challenges and risks but mitigation plans have been implemented where possible and necessary.

Appendices:

- Appendix 1 - Trust Objectives 22-23 Q3 Report

BARNSLEY HOSPITAL TRUST OBJECTIVES 2022–2023 – RECOVERY, BUILDING BACK BETTER AND FAIRER Q3 REPORT

Barnsley Hospital NHS Foundation Trust

RAG Key

	On Track
	Issues but Mitigation in Place
	Significant Issues/Delays
	Complete

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life		
Strategic Goal Priorities	1. **Best for Patients & The Public** - We will provide the best possible care for our patients and service users	2. **Best for People** - We will make our Trust the best place to work
	3. **Best for Performance** - We will meet our performance targets and continuously strive to deliver sustainable services	4. **Best for Place** - We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
	5. **Best Partner** - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	6. **Best for Planet** - We will build on our sustainability work to date and reduce our impact on the environment

1. Best for Patients & The Public - We will provide the best possible care for our patients and service users

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Jackie Murphy Simon Enright	We will deliver our defined quality priorities for 2023/24 and safe compassionate care by seeking, visiting and learning from exemplary organisations. Delivery measured by: RAG / Q3 Formal complaints & concerns regarding communication & failings in compassionate care reduced by 10% (51 - 21/22) — 36 YTD 82 Front-line staff trained in customer care – 50% (90% by year 3). — - BHNFT to be consistently placed in the top 20% of acute providers in all national patient surveys. — TBC Staff trained in Quality Improvement (QI) introduction by 2023 - 70% plus 5% further trained in QI Foundations — 68% Achieve 95% compliance with Venous — 97% *(Oct 22)*	• Achieve the 2022/23 targets aligned to each of the quality priorities with monthly reporting on KPIs/progress via Quality & Governance Committee: **Clinical Effectiveness** ▪ Ensure mortality indicators are within statistically expected confidence limits. ▪ Use intelligence to understand unwarranted variation in outcomes to drive improvements in clinical services. ▪ Implement systems to prevent avoidable harm. ▪ Continue to strengthen our preventive medicine for all patients through our Healthy Lives Programme. ▪ Enhance clinical decision-making and target it at those in greatest need first, using information and support related to health inequalities and the wider determinants of health (guided by Core20Plus5 approach and our public health action plan).	Mar 2023	Amber	Lots of work continues to deliver our quality priorities for 2022/23 and actions are overall on track but formal complaint numbers and slow progression regarding customer care training has rated this objective amber. Turnaround time and quality of complainant responses has greatly improved and on reflection given the post pandemic affects and on-going challenges a reduction in complaints was unlikely in 2022/23. **Clinical Effectiveness** • Mortality Indicators remain within statistically expected confidence limits and are reported monthly to Clinical Effectiveness Group (CEG) & Quality & Governance Committee • SPC reporting is now being adopted to present falls and pressure ulcer data to enable teams to identify areas for improvement and take appropriate action. • The Trust continues to use Tendable (previously Perfect Ward) audit methodology to measure and assess standards of care to prevent avoidable harm. In quarter 3 average score compliance for falls prevention was 97%, pressure ulcers was 85%, dementia was 78%. Further work is being undertaken with the relevant and specialist teams to improve compliance. • The Healthy Lives Programme and Team has undergone a post-pandemic learning and development review resulting in a number of actions, including Alcohol Care Team (ACT) becoming an early adopter for the Trust of Care Flow Connect digital ward system, plans to build the BI capacity and a specific QUIT improvement plan and recruitment to expand the tobacco control programme. • The Trust has improved its measurement of a number of services against inequalities, including QUIT delivery, A&E activity, the RTT and patient treatment list, outpatient DNAs, sepsis pathway through the support of the Health Education England (HEE) Leadership Fellow. This work is continuing to develop, including to inform service improvement plans to reduce inequalities identified.

	Thromboembolism (VTE) screening.	
	Achieve 90% antibiotics given within an hour for Sepsis.	86% *(Q2)*
	60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	81%
	Delivery of Health Inequalities action plan metrics.	

Note: Percentages rounded

Patient Safety

- Ensure plans in place for safe staffing across all clinical areas, monitored through Quality & Governance Committee for Medical, Nursing & Midwifery, Allied Health Professionals and Health Care Scientists.
- Proactively implement improvements to keep our patients safe, using Quality Improvement (QI) methodology where appropriate.
- Prevent avoidable patient deterioration (NEWS2 for unplanned Critical Care Unit admissions, Venous Thromboembolism (VTE), Sepsis).
- Implementation of the Patient Safety Specialist role within the organisation.
- Develop work programmes to support the implementation of the NHS Patient Safety Strategy – Safer Systems, Safer Patients.
- Provide care that is compassionate, dignified and respectful balancing both the physical and mental health of our patients and service users.

Patient Experience & Engagement

- Actively work with partners to understand, prioritise and deliver improvements to our Mental Health services within the remit of BHFNT for patients and those important to them.
- Engage with patients who have received care for their mental health condition whilst in BHNFT to inform improvements in relation to the environment and access to services.
- Recruit and embed Enhanced Support Volunteers to adopt an individualised patient-centred approach to patient experience.
- Provide care that is compassionate, dignified and respectful balancing both the physical and mental health of our patients and service users.
- Deliver a chaplaincy plan to meet the pastoral, spiritual or religious needs to all in our care.

Quality Improvement

- Continue to develop the QI Team to full establishment.
- Further develop and build on the improvement capability across the organisation.
- Promote the importance of patient and public representation in our improvement endeavours by having volunteer representation at the Proud to Improve Group and ensuring a patient focus in Quality Improvement projects.

Dec 2022

Dec 2022
Mar 2023

Mar 2023

Amber

Patient Safety

- Any urgent patient safety issues are addressed at the weekly Patient Safety Panel. The Patient Safety Specialist provides a monthly report and assurance on the National Patient Safety Updates to the Panel
- QI methodology is used to improve patient safety and a local inventory of improvement work is held and is available for all staff to view via the QI team's intranet page. Monthly QI reports are produced for CEG and CBU Business & Governance meetings. *(See QI update)*
- NEWS2 metrics are on track for delivery. In Q2 In-patient areas are achieving the 90% compliance for sepsis but 90% of patients received antibiotics within 1 hour 32 minutes in ED against the 1 hour target. Q3 data currently unavailable.
- There are now minimal Registered Nurse vacancies across nursing areas with 190 internationally educated nurses recruited and 35 newly qualified nurses commenced between September and November 2022, following an ICS standardised approach which will continue into 2023.
- A successful HCSW recruitment round and open day in October took place to further reduce HCSW vacancies. Further open days to be planned across 2023.
- We have 22 Year 1 and 20 Year 2 trainee nursing associates and are currently recruiting a cohort of 13 to commence in February 2023.

Patient Experience & Engagement

- Work continues with Place partners to describe the Mental Health service provision into BHNFT. A subgroup of the BHNFT Mental Health steering group has been established. Meeting taken place with members of Barnsley Mental Health forum, suggestions shared on engagement opportunities and members invited to join the BHNFT steering group as core members.
- The developing role of the Enhanced Support Volunteers continues to be supported by growing numbers of volunteers, with 45 Enhanced Support Volunteers now active. There are currently 158 people actively volunteering in roles across the Trust and a further 60 potential volunteers currently going through the recruitment process.
- Progress in the delivery of the Chaplaincy service improvement plan is on track for effective and timely delivery providing assurance that the Chaplaincy service is being delivered in line with NHSE Hospital Chaplaincy Guidelines.
- A number of quality improvements are being made as a result of the 2021 Inpatient survey results and it is expected the impact and effectiveness of the quality improvements will demonstrate sustained improvements in all associated areas of patient experience improving the survey score for 2022 which is published in summer 2023.
- A dedicated customer care course hasn't been delivered due to operational pressures and associated challenges in releasing colleagues from clinical duties. The Trust however has taken forward enhanced care and QI programmes and in pursuit of quality including a caring behaviour and action that each member of staff wants to take forward and adopt.

Quality Improvement

- Delays have been encountered with HR processes during the QI team expansion. A review is being completed to understand the establishment required for maximum support for the organisation.
- As at end of Q3 67.53% of staff have completed the QI Introduction training module, on track to achieve 70% of staff by April 2023. 226 staff have completed QI Foundations training (7.51% of staff).
- Work continues to look at how environmental sustainability, health inequalities and equity can be incorporated into quality improvement work to support the anchor institution agenda. Training and the QI resource pack is

<table>
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<td></td>
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<td>▪ Build on the work already taken place with the use of Statistical Process Control (SPC) charts in the Integrated Performance Report (IPR) to progress and measure QI across the organisation.</td>
<td>Jun 2022</td>
<td>Amber</td>
<td>being reviewed to also support this including the use of tools such as the vulnerability index.
• There are currently 10 QI projects with outcome measures associated with the anchor and sustainability agendas for example the sustainable waste management in anaesthesia & critical care. The team identified that adhesive sharps pad could be removed from the arterial line packs and work is ongoing to understand the full benefits from a sustainability and environmental perspective.</td>
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<tr>
<td>Jackie Murphy</td>
<td>We will continue to listen to our patients and involve them in decisions about their care.

Delivery measured by:

<table>
<tr><th>RAG</th><th></th><th>Q3</th></tr>
<tr><td></td><td>All areas in the Trust >95% Friends & Family Test (FFT) positivity rate.</td><td>91% (88% Q2)</td></tr>
<tr><td></td><td>Number of real-time improvements made in inpatient areas.</td><td>TBC</td></tr>
</table>
</td>
<td>• Co-design and deliver the Trust ‘Always Events’ with Service Users and the public through the Always Campaign with delivery planned across all quarters.
• Develop further methods of patient and public feedback to inform a plan to drive a customer service mind-set across the organisation.
• Implement local patient feedback dashboards to provide real-time collection and response to feedback provided across all in-patient areas.

• Embed tools developed to ensure the patient’s voice is represented in the delivery of care, design and re-design, and that the voice of those with poorest access to health and care is included (guided by Core20Plus5 approach and our public health action plan).
• Consideration specifically given to people from BAME backgrounds, people with learning disabilities, and those with autism when designing or improving the services we deliver.
• Forge connections with groups within Barnsley Hospital and the wider Barnsley community and share feedback to support a seamless patient experience across Barnsley Services.
• We will ensure patients and families continue to receive learning and feedback from serious incident investigations but also receive feedback on the implementation of actions.</td>
<td>Mar 2023

Sep 2022

Sep 2022

Dec 2022

Mar 2023

Dec 2022

Dec 2022</td>
<td>Amber</td>
<td>• As part of the BHNFT Always Campaign all CBUs have implemented at least one focus event based on known feedback themes from patients, carers and families. The initial aim was to undertake 5 events but due to operational pressures, consistent implementation across the CBUs has been challenging. Further work will take place during Quarter 4 and the Director of Nursing & Quality and Head of Quality & Clinical Governance are revisiting plans for the continued roll-out of the campaign. This objective will continue to be a key focus during 2023/24.
• Limitations have been identified with the SMS real time patient feedback system rollout therefore the executive team agreed to support an external SMS solution and is anticipated to be in place by Quarter 1 2023/24. It is anticipated that this solution will collate patient feedback, increase trust response rates, support the development and implementation of ward/departmental level real time patient feedback dashboard to make improvements promptly. The >95% positive FFT rate continues to be challenging to meet however overall positivity rate has improved in Q3 to 91%. The Emergency Department continues to experience operational pressures impacting on waiting times which is reflected in feedback.
• Engagement work and collaborative working is active and focussed across a number of groups and communities in Barnsley; Barnsley Carers, Chilypep, BMBC, Barnsley Hard of Hearing Group. A number of service design and re-design projects have progressed in quarter 3 including; Ward 19 CoE, Community Diagnostics Phase 2, Haven Room (children’s ward).
• Supporting the place-wide approach to bowel cancer screening for people with LD and improving the Barnsley shared registers for people with LD and autism. Maternity services are taking forward work around BAME communities.
• 100% of patients and families continue to receive learning and feedback from serious incident investigations. From quarter 3 all patients and families will receive feedback on the implementation of actions following a Serious Incident.</td>
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<tr>
<td>Simon Enright</td>
<td>We will focus efforts on recovery of core research activity, restart the development of non-Covid related commercial and innovation activities affected by the pandemic.

Delivery measured by:

<table>
<tr><th>RAG</th><th></th><th>Q3</th></tr>
<tr><td></td><td>Deliver increased income associated with Commercial research comparing back to pre-COVID targets.</td><td>TBC Q4</td></tr>
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</td>
<td>• Build on Covid research and re-start core research activity and commercial activities affected by the pandemic.
• Seek relevant opportunities to adopt multi-centre pandemic-related research studies.
• Develop processes for staff to access support with the delivery of innovations across the Trust.</td>
<td>Mar 2023

Mar 2023

Dec 2022</td>
<td>Green</td>
<td>Research activity is supporting the Efficiency and Productivity Programme with £240k+ of savings identified through the R&D department work.

• Complete. All core research trials paused during COVID have now restarted to active patient recruitment
• First commercial study post COVID - RSV paediatric vaccine trial has successfully recruited and exceeded it’s recruitment target. Continue to review research studies for feasibility. The covid related study pipeline has slowed significantly so have focused on opening studies in other various clinical areas with a larger pipeline of work in line with the R&D strategy.
• Innovation team are currently supporting a number of initiatives, in line with available capacity, in particular: SkinVision and Preeclampsia Testing. A request for increased resource to support clinical and operational teams, through extending the hours of the team is being considered.</td>
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• Progress systems to capture and monitor research studies and innovation projects.

• Continue to promote, communicate and embed the Innovation support available including access to the dedicated Innovation website.
• Maintain close working with the Integrated Care System (ICS) and regional partners to support delivery of Innovation in the Trust.
• Develop plans to take forward our aspiration to create a new research facility over the next 3-5 years.
</td>
<td>Dec 2022

Dec 2022

Sep 2022

Mar 2023</td>
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<td>
• Close links are maintained with the Yorkshire & Humber Academic Health Science Network to identify any new suitable innovations. We also have links through the ICB and P4SY organisations supporting the innovation workstream
• Complete - System in place to capture and monitor study pipeline and feasibility information. Study opportunities are shared with the Trust, individual CBUs and clinical teams.
• Continued development of research website to include CBU specific information on research being undertaken and opportunities. Promotion of this now embedded in CBU business and governance monthly meetings.
• Continue to attend all regional meetings to share best practice and keep up to date with developments. Initial meeting undertaken with SWPYT to discuss opportunities for collaborative working.
• Updated research strategy in development to be launched in Q4 2022-23 to address priorities for next 3-5 years. Continue to meet with Estates regarding potential space for a dedicated research facility
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<td>Tom Davidson</td>
<td>
We will continue to use digital transformation to support new ways of working and will build on solutions that enable our teams to work fully electronically and remotely in 2022/23.

Delivery measured by:

<table>
<tr><th>RAG</th><th></th><th>Q3</th></tr>
<tr><td></td><td>Benefits outlined in Electronic Documents and Prescribing projects roadmap.</td><td>TBC</td></tr>
<tr><td></td><td>High NHS Transformation Directorate Digital Maturity Assessment score.</td><td>On Track</td></tr>
<tr><td></td><td>25% of Paper forms converted to digital during 2022-23.</td><td>TBC*</td></tr>
<tr><td></td><td>Healthcare Information and Management Systems Society (HIMSS) Digital Maturity – Continually assess our position and build a plan to manage gaps.</td><td>On Track</td></tr>
</table>
*Exercise being undertaken to baseline number of paper forms to assess conversion
</td>
<td>
• Further roll out of E-prescribing (Phase 2) including Outpatient Services.
• Build a detailed roadmap to maximise the benefits of our Electronic Documents and Prescribing projects.
• Deliver national priority to have fully costed 3-year investment plans finalised in line with “What Good Looks Like” framework along with the priorities set out in the national priorities and operational planning guidance.
• Digitally enhanced ways of working for staff that enable them to work fully electronically and remotely where appropriate.
• Develop the 3rd Phase of our Electronic Patient Records Strategy to include record sharing and capturing clinical notes and documentation digitally at source.
• Start Initiation of phase 3 projects including:
  ○ Citizens portal – Patient Access to their own records and appointment scheduling;
  ○ Record Sharing – Submit our clinical records for access by our neighbouring NHS partners;
  ○ Virtual Clinics/Wards –Improve our remote monitoring to increase clinical confidence in this approach;
  ○ Clinical Notation/ Workspace – Reduce our paper burden by replacing all paper assessments;
  ○ Deliver strategic Robotic Process Automation outcomes that increase our efficiency to remove human intervention from repetitive, system-based tasks.
• Bid for all sources of funding to support our Published Digital Transformation Strategy.
• Understand our digital maturity gaps by analysing our position against the NHS Transformation Directorate “What Good Looks Like” Framework and build an improvement plan.
• Research the opportunities available through enhancement of the business intelligence offer to Trust teams.
• Continue to work with the Barnsley Place Digital Inclusion Steering Group to assist and maximise the opportunities for our patients to increase their digital understanding, access and reduce health inequalities.
</td>
<td>Mar 2023
Mar 2023

Jun 2022

Sep 2022

Mar 2023

May 2022

Mar 2023

Mar 2023

Mar 2023

Mar 2023</td>
<td>Green</td>
<td>
• We are presently implementing the first part of EPMA Phase 2, Fluids and Infusions, with a plan to implement in Feb 2023. Eprescribing Outpatients will commence in Q3 with and expectation of a pilot in Q4. EPMA in Maternity Expected Q1 to Q2 2023/24.
• Improvement plans are in place and currently in implementation for EDMS and EPMA.
• A new Patient Communication tender has been completed with a view to implementing the Patient Portal to enable access to personal letters and appointments. A rollout plan is being agreed.
• The Shared Care record project across the local area with implementation agreement signed off by the executive team ready to engage supplier for technical delivery.
• A Project Initiation Document has been prepared for Clinical Workspace which will follow on from a demonstration to the Clinical Effectiveness Group. Shared Care Record is progressing across the ICB. Trusts are submitting data for sharing baseline information.
• Robotic Process Automation Project for Electronic Referrals to remove administration overheads and facilitate sharing is now in implementation phase.
• £6M Bid over 3 years is now complete for Minimum Digital Foundations funding awaiting treasury approval to finalise internal business case to complete necessary governance approval.
• Our assessment against “What Good Looks Like” is now complete and we are preparing ourselves for the new “Digital Maturity Assessment” under McKinsey expected Jan 2023.
• New Stakeholder group has been established for the use of Power BI to support the management of our Patient Waits.
• Digital inclusion workshops and training in place for our citizen’s. Further work planned to publish opportunities to improve inclusion.
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<td>Lorraine Christopher</td>
<td>We will continue the development of our estate including a new Critical Care Unit build and delivery of capital programme in 2022/23.</td>
<td>
• Opening of Critical Care Unit build.
• Finalise build and deliver additional diagnostic capacity in the Community Diagnostic Centre (CDC) at the Glassworks shopping centre in the heart of Barnsley.
</td>
<td>Dec 2022
Jun 2022</td>
<td></td>
<td>
• The Critical Care Unit (CCU) building works have had slight delay and extension of time has been granted. A longer commissioning period is anticipated due to the sensitivity of the unit but hand over is expected in Q4. Opening of the
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Rob McCubbin Bob Kirton	Delivery measured by: • Improvements to the built environment. • Critical Care Unit (CCU) activity taking place in the new setting. • Diagnostic activity taking place at Glassworks.	• Complete as appropriate other prioritised capital schemes as managed through Capital Monitoring Group, including backlog maintenance. • Completion of Trust Estates Strategy 2022-27 with alignment to the Barnsley Place, service needs set within the context of the ICS Estates Strategy and principles of our anchor charter where appropriate. • Review capital development priorities building from the Estates Strategy. • Continue to review the efficiency of the estate ensuring optimal use for clinical activities, to be reported monthly through Space Utilisation Group. • Review further development of health and wellbeing space for our patients, visitors and people. • Report and contribute to South Yorkshire & Bassetlaw (SYB) ICS Estates Board to understand the role of the estate within the region and agree any appropriate timeframe for actions arising. • Contribute and input to the development of Barnsley Place Estates Strategy as appropriate.	Mar 2023 Jun 2022 Mar 2023 Mar 2023 Mar 2023 Mar 2023 Mar 2023	Green Green	Critical Care Unit planned for Q4 with the contractor to complete February 2023. • CDC completed. Fantastic feedback was received from patients and staff alike. CDC expansion to MRI/CT is now in development as a result of a successful bid and delivery of the original CDC in support of regeneration and provision of accessible town centre treatment. • Works progressing with the Estates Strategy and consultation; this is planned to be presented to Senior Leaders in January 2023. • Capital Monitoring Group continues to coordinate spending and tracking against the capital programme, with ongoing estate work going to plan, along with medical and surgical equipment prioritisation confirmed in December 2023 ahead of the procurement in Q4. • Monthly space utilisation group continues where efficiency and opportunities are reviewed. • A number of health and wellbeing schemes are progressing, such as the Theatre changing rooms which have now been designed and tendered. Subject to final funding approval, this is anticipated to commence in March 2023. • Contribution and input into Barnsley Place Estates Strategy have so far included a strategic estates meeting and South Yorkshire Open Public Estates (OPE) development fund workshop. Despite slight delay in CCU build this objective is still on track for in year delivery and has made fantastic progress in attracting funding for a second CDC unit.

2. Best for People - We will make our Trust the best place to work					
Lead Director	**Objectives (including key metrics to measure success)**	**Key Actions and Milestones**	**Completion Date**	**RAG Status**	**Progress Update**
Steve Ned	We will develop a caring, supportive, fair and equitable culture for all and create an organisational climate that supports Equality, Diversity and Inclusion. Delivery measured by: RAG / Freedom to speak up champion numbers. / Q3: 18 (+2 in Q3) Reduction in proportion of staff who say they have personally experienced harassment, bullying or abuse at work in the last 12 months. / TBC * Increase in proportion of staff who agree their organisation acts fairly with regard to career	• Produce an action plan to embed the actions arising from the work started to create a positive workplace culture. • Develop a programme of professional nurse advocacy and recruit 10 Professional Nurse Advocates (PNAs) during 2022/23. • Promote the revised branding in respect of our values including addition in key documents and templates. • Aim to increase our staff survey response rate from 56% to 65% and achieve a staff survey overall engagement score in the top 20%.	Apr 2022 Mar 2023 Apr 2022 Feb 2023	Green	• Complete. Positive Culture action plan produced and quarterly progress reports provided to People & Engagement Group and People Committee. Recent progress includes:- ○ Completion of Just & Restorative Culture training via Northumbria University in order to roll out a new approach in management of employee relations issues throughout 2023 ○ Working on revisiting structure and action plans for Positive Culture group, including additional workstream on Conference and new actions for Restorative Just Culture following attendance at training ○ Planning further development at senior leadership level – Board Team Development; Senior Leaders Forum; Rotherham/Barnsley joint senior leader programme • Complete. The Trust now have 12 Qualified PNAs and a further 19 in training. There have been 20 restorative clinical supervision sessions delivered during Q3, as well as 17 career conversations and a total of 24 QI projects are underway as a result of issues and ideas generated through the restorative supervision sessions. • Complete. Simplified and easily memorable values words and strapline – Respect, Diversity, Teamwork – agreed and launched in Trust Strategy document, leaflets and posters. Use of branding to be expanded into other documents and templates • PICKER response rate for 2022 is 59% including BFS responses which will be removed in the NHS report. The average response rate for similar

	progression/promotion from (a) BAME staff, (b) white staff, (c) women.					organisations is 46%. The Trust's overall positive score is ranked 6th in all Picker acute and acute community trusts, compared to being in 10th position in 2021.
	Increase in the organisational staff engagement score as measured by the staff survey.	TBC *	• Create an improvement plan and actions to address the key areas of concern in the 2021 staff survey, including staff availability and staff not coming to work when not feeling well enough to perform duties.	Apr 2022		• Complete. 2021 staff survey results action plan produced and quarterly progress reports provided to People & Engagement Group. New approach to staff survey results action planning with CBUs to be proposed and implemented in Q1 2023/24 – more support provided whilst being clear on local ownership
	Workforce Race Equality Standard (WRES) Model Employer race disparity ratios across the three tiers of all Agenda for Change (AfC) bands	Baseline Work Done Oct 23 Next Report	• Build on the work already done and actively encourage staff to join the staff equality networks including provision of protected time to the Chairs of the staff networks to be able to fulfil their roles fully. • Further develop and increase the number of freedom to speak up champions across the Trust.	Apr 2022 Oct 2022		• Complete and ongoing. Increased access to Staff Networks as a safe place to create opportunity for colleagues to improve their workplace and also create more ownership for colleagues to be involved in wider aspects of the organisation. • Complete. The Trust now has 18 FTSU champions, who are now trained and active in their roles across the Trust. Increased visibility of FTSU Guardian on wards to offer support and listen to concerns.
	Recruit 10 Professional Nurses Advocates during 2022/23.	12 Recruited **	• Create plans to deliver the NHS People Plan six high impact actions to overhaul recruitment and promotion practices to ensure the workforce reflects the diversity of our communities. Related work includes: Setting WRES Model Employer goals, ensuring all staff have measurable objectives on equality, diversity and inclusion and develop plans to deliver the inclusive cultures reciprocal mentoring programme to a second cohort of aspiring and established leaders.	Sep 2022	Green	• Trust staff network chairs participated in the production of an ICS staff networks promotional video now available on YouTube . ET paper being prepared for protected time for Staff Network Chairs & Deputy Chairs - January 2023 • A successful disability history month event took place and we were able to engage with 70 staff to promote disclosing disability status on ESR. • Exploring ways to create inclusive recruitment opportunities. Recruitment guidance updated to include adoption of EDI values-based approach. Workforce Representation and recruitment practices to be reviewed to strengthen accountability for recruiting panels. • Pilot to be introduced to establish cohort of diverse panellists - April 2023. Second cohort of Inclusive Culture Programme not confirmed, details to be provided in due course • Both the ICB schools Liaison team and the Barnsley hospital ambassadors have supported a variety of school events in total, collectively 326 hours of liaison has been provided to reach 560 participants in the Barnsley district. • Consultant in Public Health working with local health partners and educational institutions, including Northern College and Barnsley College, to establish the Barnsley HSC Academy and more generally improve local education, employment and professional development. Supporting the Barnsley 2030 Board and Inclusive Economy Board to commit to actions to reduced inequalities, including promoting the real living wage.
			• Develop our approach to recruitment, employment, and education in Barnsley in line with the principles in our anchor charter, supporting people from the most deprived backgrounds into good and secure employment	Mar 2023		

*Reliant on staff survey results
**Plus a further 19 in training

Steve Ned	We will continue to ensure that we retain our staff and explore all opportunities to recruit to all vacancies across the Trust in 2022/23, including exploring innovative approaches where appropriate, and to ensure our organisation is correctly resourced. Delivery measured by: RAG / Increase in the percentage of staff who say they are satisfied or very satisfied with the opportunities for / Q3: TBC *		• Increase and showcase the number of flexible working arrangements across the Trust to create an inclusive and flexible working culture. • Maximise the use of the e-rostering system to include the facility for team rostering and increase the level of attainment in the NHSEI standards for e-rostering and e-job planning. • In line with national priorities and our anchor charter, leverage the role of the Trust as anchor institution and create training and employment opportunities including delivery of a 12-months supported internship programme for a cohort of young people with learning disabilities and/or autism in partnership with local providers. • Utilise the enhanced range of apprenticeship frameworks available to develop our workforce needs for the future • Respond to the national planning guidance ask to expand ethical international recruitment and scope potential for the development of a	Mar 2023 Mar 2023 Sep 2022 Feb 2023 Mar 2023	Amber	• New flexible working group set up for January 2023 to review our approach and access to flexible working and fair rostering opportunities, initially focusing support on our nursing and midwifery colleagues • Check and challenge meetings continue with CBU3 supported by the rostering team to encourage effective use of health roster. Action plan on track in response to roster audit to increase assurance and visibility of roster utilisation to meet level of attainment (level 2) reporting to PEG monthly. • Placements for people with LD and autism have been established with 9 young people with learning disabilities & Autism are undertaking DFN Project Search internship programme • There are currently 90 staff on advanced level apprentice frameworks across the Trust and specialisms, some of which have not been previously utilised. • There are now minimal Registered Nurse vacancies across nursing areas with 190 internationally educated nurses recruited

	flexible working patterns.		community of practice to support internationally educated nurses to stay and thrive. • Continue to utilise the national Healthcare Support Worker (HCSW) recruitment and retention programme offered by Health Education England (HEE) and NHSE&I, and utilise development opportunities for unregistered staff to become registered.	Mar 2023		• We have an established pipeline of career progression for unregistered health care support workers to become Nursing Associates (NAs) or Registered Nurses (RNs) and have a 'top-up' conversion programme for NAs to become RNs with our first cohort qualifying in March 2023. Successful HCSW open day held in October, interviewing candidates on the same day, we aim to have zero vacancy position following next round of interviews in January 2023 • We have 11 trainee advanced clinical practitioners within nursing and radiography with an additional 3 trainees to commence in January 2023 • Active participation continues in the Barnsley Place v-fairs this year. At the last event there was a focus on clinical support workers and domestics recruitment • A fourth cohort of Calderdale Framework facilitator training in Jan 2023 is scheduled • A review of digital on-boarding systems has been completed and a preferred supplier identified. The project and development of a business case has been deferred until April 2023 following the full Trust roll out of the new NHS Jobs Service and the release of recruitment team capacity • Project team agreed ESR Self-service approvals process. Business case in progress to request resource to proceed with implementation and maintain BAU. • Turnover data and reason for leaving included in a new quarterly workforce performance report (CBU1,2,3 & BFS) where potential preventable leavers are highlighted along with length of service before leaving to help inform action plans.
	Increase in the percentage of rosters approved and published at least six weeks in advance of the roster start date.	Expected Q4				
	New to care HCSW numbers.	51 YTD Recruited ***	• Accelerate the introduction of new roles, such as anaesthetic associates and expanding advanced clinical practitioners. • Participate in the Barnsley Place health and social care employers' joint virtual recruitment fairs during 2022/23.	Mar 2023 Apr 2022		
	Increase NHSEI level of attainment for e-rostering for nursing and midwifery staff group to Level 2, and for e-job planning for medical and dental group increase to level 1.	Nursing Level 1 E-job Plans Level 1	• Implement the Calderdale Framework to review and assess new roles and skill mix within nursing establishments fit the needs of the service. • Review and assess merits of sourcing a visually attractive and digitised on-boarding solution.	Mar 2023 May 2022		
	Recruit a further 100 international nurses.	100	• Fully implement the electronic staff record (ESR) Manager Self-Service functionality across the Trust. • Analyse vacancy metrics including review of long term and short-term gaps and turnover metrics including review of leaver destination e.g. promotion; internal/external.	Mar 2023 June 2022	Amber	
	Decrease in the Trust vacancy rate.	5.3% 5.7% Q2 4.05% Baseline				
	*Reliant on staff survey results **All HCSW type roles – not specific to new care as not identifiable					
Steve Ned	We will continue to provide and enhance the health and wellbeing support (including psychological support) for our staff in 2022/23. Delivery measured by:		• Embed the Trust's Health and Wellbeing offer post-pandemic, including reviewing and identifying which areas to enhance or evolve. • Further develop and increase the number of health and wellbeing champions across the Trust. • Progress plans for meeting the 'Thriving at Work' mental health and wellbeing Framework six core standards. • Increase and promote access to informal resolution interventions for workplace conflict and access to structured learning and reflection sessions, i.e., facilitative group discussion, mediation and Schwartz rounds. • Progress plans to identify and support our staff who are carers including introduction of a peer support group and a revised carer leave policy. • Develop line manager capabilities and offer support for them to be able to provide regular one-to-one health & wellbeing conversations (including discussing equality, diversity and inclusion matters) with their staff. • Build the Pulse Check staff engagement results and other health and wellbeing metrics into a balanced scorecard performance dashboard of	Jun 2022 Oct 2022 Mar 2023 Apr 2022 May 2022 Jun 2022 Apr 2022	Green	• Task & Finish group set up in Nov 2022 to complete the NHSI/E self-assessment diagnostic tool to establish a baseline data and gap analysis against the health & wellbeing framework standards. Due to complete in Feb 2023. • Complete. 51 Health & Wellbeing Champions have been trained and attended training sessions. • Internal audit of Trust's health and wellbeing offer final report and findings due to be presented to Exec Team in January 2023 to inform next steps and action plan. Self-assessment taking place against the NHS England Health & Well Being framework • Positive Culture Dashboard created highlighting prioritised metrics, approved at People Committee and shared with the ICS • New working carers peer support group set up and first meeting held in December. Increased family friendly leave proposal paper and metrics to be presented to Exec Team in Feb 2023. • Courageous conversations toolkit and training course launched. • Positive Culture Dashboard created highlighting prioritised metrics, approved at People Committee and shared with the ICS

RAG		Q3
	Health and wellbeing champions numbers	51 Trained
	Progress towards meeting the 'Thriving at Work' mental health and wellbeing Framework core standards	Baseline stage
	Facilitative discussions, mediation sessions and Schwartz rounds numbers	Year End reported Q4

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<tr>
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<tr><td></td><td>Improvement in uptake of workforce healthy lifestyle services</td><td>Year End reported Q4</td></tr>
<tr><td></td><td>Reduction in percentage of staff saying they experienced at least one incident of violence at work from patients/relatives/public.</td><td>TBC *</td></tr>
<tr><td></td><td>Reduction in proportion of staff who report that in the last three months they have come to work despite not feeling well enough to perform their duties.</td><td>TBC *</td></tr>
</table>
*Reliant on staff survey results
</td>
<td>workforce performance indicators. Introduce an annual workforce health needs assessment survey to identify and act upon priorities for staff.
• Deliver the violence and aggression reduction action plan recommendations via the Violence & Aggression Management Group in order to provide strengthened support to staff.</td>
<td>Mar 2023</td>
<td></td>
<td>• Work continues in delivering the actions set out in the violence and aggression reduction action plan and reports to the violence and aggression management meeting every two months and is on track for delivery.</td>
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<td>Steve Ned</td>
<td>We will continue to develop our leaders and staff in 2022/23 trusting our staff to care for our patients to a high standard and supporting them to continuously improve their own work and the work of others.

Delivery measured by:
<table>
<tr><td>RAG</td><td></td><td>Q3</td></tr>
<tr><td></td><td>Work mentor and coach register numbers</td><td>To be reported Q4</td></tr>
<tr><td></td><td>Degree and Master’s level apprenticeships numbers</td><td>To be reported Q4</td></tr>
<tr><td></td><td>Talent and Leadership development programmes numbers</td><td>To be reported Q4</td></tr>
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</td>
<td>• Develop programmes to support and enable the Trust workforce to be digitally enabled in support of the Trusts digital agenda.
• Develop and refine our approach to talent management and succession planning including developing structured career. coaching conversations, structured access to work shadowing opportunities, coaching and mentoring, and the identification of roles and individuals for a talent pipeline using a critical role tool and succession management tool.
• Support our leaders in using apprenticeship frameworks to access degree and masters level leadership development apprenticeships.
• Continue training of postgraduate doctors, with adequate time in job plans of supervisors.
• Deliver sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible.
• Offer focussed support and guidance for leaders managing and developing remote teams and geographically dispersed teams over the longer- term post-pandemic.</td>
<td>Mar 2023

Mar 2023

Apr 2022

Mar 2023

Mar 2023

Jun 2022</td>
<td>Green</td>
<td>• Leadership and OD Strategy including Talent Management and Succession under development and due March 2023. Agreed recommendations in relation to these areas will be designed and implemented from April 2023 onwards.
• 2023 Aspiring/Arising/Ascending Talent Programmes ready to commence in January 2023.
• A slight increase in Mentor and Coach register numbers, but they remain low. Consideration will be given as to how we might expand as part of the OD Strategy.
• Clinical placement capacity has expanded across nursing across 2022 and we continue to work very closely with HEIs to accommodate requests. Due to large deficits in placement hours for nursing students qualifying in 2022/23, we have offered additional ‘make-up hours’ to ensure timely integration into the registered workforce. We have worked closely with the Physiotherapy and Occupational Therapy Service Leads to expand clinical placement capacity within those professions for academic year 22/23. There will be a focus on clinical placement expansion across midwifery across 2023.
• New Hybrid working policy and toolkit in development. Expected completion date Jan 2023.</td>
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3. Best for Performance - We will meet our performance targets and continuously strive to deliver sustainable services					
Lead Director	**Objectives (including key metrics to measure success)**	**Key Actions and Milestones**	**Completion Date**	**RAG Status**	**Progress Update**
Lorraine Burnett	We will deliver the urgent care programme in 2022/23 to support best performance. Delivery measured by: • Aspire to eliminate 12-hour waits in the Emergency Department. – DTA 12h 63 breaches (Dec) • Eliminating ambulance handover delays of over 60 minutes. – >60 minute waits occurred in Q3	• Expand the virtual ward model to further specialities to support the national ambition of 40-50 virtual beds per 100,000 population. • Deliver against the actions and metrics in the Barnsley Urgent & Emergency Care (UEC) plan specific to the Trust and support others in the place with their work. • Strengthen our public health analysis of urgent and emergency care activity, including based on inequalities, and develop a more holistic approach to reducing need and demand (in line with our public health action plan) • Deliver against the improvement pathway relating to avoiding unnecessary attendances at A&E, including those patients with a primary care presentation and developing further alternatives pathways for care e.g. Front door service development and care closer to home initiatives. • Assess the options for progression of an Urgent Treatment Centre (UTC) in line with ICS strategy for delivery of urgent care. • Develop plans to work with the new emergency care standards locally and at system level. • Maximise overall bed capacity to include Same Day Emergency Care. • Manage Length of Stay and utilise the right to reside criteria in support of patient flow and reducing hospital-associated deconditioning. • Ensure Directory of Services is up to date and maintained effectively to facilitate appropriate use from NHS 111.	Sep 2022 Mar 2023 Mar 2023 Mar 2023 Mar 2023 Mar 2023 Sep 2022 Sep 2022	Amber	For the first 2 months of the third quarter performance was relatively stable however from December onwards performance significantly deteriorated due to the emergent urgent and emergency care pressures experienced nationally. • Virtual ward operational, funding agreed and recruitment ongoing to increase current capacity. • Quarter 3 has seen a deterioration in performance across the UEC pathways. No outstanding actions for BHNFT in the Barnsley UEC plan • Ongoing work is taking place regarding how to approach health inequalities within current pathways and planning. Established routine analysis of A&E activity by deprivation, gender, age, local geography. Worked with the Barnsley Health Intelligence Group to analyse Barnsley-wide HSC pressures. • Improved the offer of socioeconomic support and preventive medicine services in UEC, including through the HLP offer and sitting the alcohol care team in A&E. • Fully engaged with the planning and information gathering for an externally facilitated workshop to develop strategy for avoiding emergency department and managing lower acuity illness & injury. Executive support to project manager. • Utilising all opportunities for resources, best practice learning at a national and regional level to support developing UEC in Barnsley and improving on current performance • Same day emergency care in place for medicine, surgery, frailty, gynaecology and paediatrics. Data submission to national benchmarking exercise and feedback awaited. • BHNFT continue to benchmark well against all discharge metrics. Increasing in length of stay have been seen with a significant number of patients meeting the criteria to reside • Directory of Service continually updated and managed by Right care Barnsley
Lorraine Burnett	We will meet all of our performance trajectories and national operational priorities in 2022/23. Delivery measured by: • Reduce number of people waiting for longer than 62 days to the level in February 2020 • Reduction of outpatient follow ups by 25% against 2019/20. – *8% (Dec)* • Patients discharged onto Patient Initiated Follow Up (PIFU) pathways – 5%. - *1.44% (Dec) against 22/23 2% target* • Sixteen Advice requests per 100 1st outpatient appointments. - *11.21% (Dec) against notional*	• Enact plans to recover cancer waiting time standards and deliver the priorities set out in the national priorities and operating planning guidance across Cancer, Elective Care, Maternity and Diagnostics. • Agree local performance trajectories by which performance will be measured, focused on patient safety in relation to nationally agreed priorities and trajectories. • Develop plans to deliver increased activity levels supporting system elective recovery: increase in 10% EL and 20% diagnostics, and target this on a greatest need basis in line with our public health action plan. • Develop and deliver agreed activity and performance trajectories annually. • Continue weekly oversight of specialty level performance & plans for delivery.	Mar 2023 May 2022 May 2022 Mar 2023 May 2022	Amber	In line with challenges experienced across the NHS the Trust is not meeting constitutional performance standards, despite this BHNFT benchmark favourably across the majority of metrics and is very near top quartile for patients waiting >52 weeks and has zero patients waiting longer than 104 or 78 weeks which is a national operational priority. • Number of long waiting cancer patients continues to decline with The Trust meeting the 2021/22 level of <50 patients but aspiring to a stretch target of 20. • Implementation of new booking rules to improve compliance on 2 week waits • Development of outpatient booking tracker for cancer, enabling increased fill rates for clinics following cancellations • Working to the agreed South Yorkshire mutual aid policy to support the delivery of no patients waiting >78 weeks across the ICS • Weekly oversight meetings on activity • Monthly theatre improvement group focused on day case rates and touch time utilisation. ADO joined weekly scheduling meeting to ensure booking rules compliance and improved utilisation rates • Involvement in South Yorkshire pre-assessment programme to reduce the number of patients arriving not fit for surgery and promote improved recovery from surgery

	12% BHNFT target (16% Place target) • Benchmark trust performance against 'best in class'.	• Begin the routine analysis of performance and activities based on health inequalities, including the disparity in use of planned and unplanned care in certain groups in the population and how we can work with partners to improve this. • Continue to reduce backlog from 2020/21 whilst ensuring return of expected referrals and undertaking 3 -month reviews for any patients waiting 78 and 52 weeks. • Develop and deliver plan to reduce outpatients follow ups by 25% against 2019/20 activity to redeploy capacity to increase clocks stops or reduce clock starts through implementation of: ○ Continue the expansion of Patient Initiated Follow Up (PIFU) pathways to further specialities; ○ Increased use of advice and guidance services.	Sep 2022 Sep 2022 Sep 2022		• Continued review of health inequalities data to consider actions required within elective recovery. Also through the commissioning of new analysis specifically on A&E attendance by Core20Plus5 measures and the recruitment to a new partner-wide PHM analyst. • PIFU is live in 12 Specialties and other services continue to hold discussions for roll-out in their areas. The number of patients moved to PIFU continues to increase. Both telephone and text and being used to validate the wait list and the use of PIFU pathways. • All services where applicable provide A&G and agreement in new financial year that RAS referrals where they are returned to referrer with advice can also be included in reporting. Requests have increased slightly, however this is now a Primary Care lead initiative as our success is dependent upon referrals from Primary Care. This is monitored via the planned care group.
Lorraine Burnett	We will continue to respond to Covid-19. Delivery measured by: • Access to Covid-19 treatment for high risk patients. • Increase the number of patients referred to post-COVID services.	• Develop plans to manage Covid-19 as business as usual. • Maintain oversight and governance process, with the ability to escalate in times of further Covid-19 outbreaks. • Continued delivery of required vaccination programmes. • Continue to respond to national priorities for Covid-19 treatment such as antiviral pathways and develop sustainable delivery models. • Improve identification of patients suitable for Long Covid pathways. • Delivery of front door point of care testing for Covid-19 and winter associated viruses. • Continue to meet Infection Prevention and Control guidance. • Ensure the Trust remain compliant with Emergency Preparedness, Resilience and Response (EPRR) regulations. • Implement Section B of our Health Inequalities action plan to ensure recovery services is done in a way to meet people with the greatest need first.	May 2022 Sep 2022 Mar 2023 May 2022 May 2022 Sep 2022 Sep 2022 Sep 2022 Sep 2022	Green	• Complete. The trust has embedded the Covid escalation framework into site management processes and is able to respond to any change in activity within 24 hrs. • Vaccination programme undertaken through 2022/23 • Complete. The Covid Medicines Delivery Unit is functional and providing access to treatments for those identified. • Process in place and on-going. • Process to support this winter in place. • Complete. The trust has embedded the Covid escalation framework into site management processes and is able to respond to any change in activity within 24 hrs. • The trust Emergency Preparedness, Resilience and Response (EPRR) manager manages all EPRR requests and attends the local resilience forum meetings to ensure the trust fulfils all actions required • The public health plan is in place and CBU's are engaged with the actions required.
Chris Thickett	We take forward work to maximise productivity and eliminating waste across our services in 2022/23. Delivery measured by: • Number of services undertaken deep dive reviews. • Efficiency & Productivity Programme delivery against target.	• Utilise quality & service improvement opportunities to improve services, provide resilience and implement innovations. • Complete a deep dive of all specialities across the Trust to identify improvements and maximise productivity. • Introduction of a robust suite of indicators empirically evidencing current productivity monitored via Trust Ops Group. • Review and implement efficiency and savings opportunities from collaborative working across Place, ICS; including joint procurement opportunities, support services reviews, peer benchmarking and joint working opportunities with TRFT. • Engage with and implement best practice clinical pathways and improvements across speciality workstreams with the ICS to provide financially sustainable services working in partnership at system and place utilising robust data for improvement.	Jun 2022 Jun 2022 Jun 2022 Sep 2022 Mar 2023	Amber	• Work is progressing as part of the EPP programme in order to improve services whilst delivering them as efficiently as possible within budget allocations. Trial work continues in CBU 2 to understand and utilise PLICS financial data in order to identify areas of improvement opportunity and theatre related cost metrics are being developed whilst the Trust awaits the latest benchmarking data. Learning from this will be used to develop a standardised approach to deep dives to inform quality and service improvement opportunities across services. • The 2023/24 EPP programme is in development and will include both internal Trust improvements along with those improvements requiring partnership working across the system to tackle. • Work continues with partners across the ICS to benefit from joint procurement exercises. Learning and best practice is shared with TRFT and DBTHFT in a PMO working group. Further work across the system is taking place in line with the GIRFT and HVLC programme which the Trust are engaged with.
Chris Thickett	We will deliver against our board approved financial plan in 2022/23. Delivery measured by: • Delivery of agreed financial plan.	• Production of robust annual business plans that have direct alignment of the service cost envelope with associated budgetary plans in line with the changing contractual landscape. • Understand the recurrent cost implications of the pandemic. • Remove capacity and costs associated with the pandemic to deliver efficiencies in line with the planning guidance assumptions and financial allocations agreed with Treasury.	Apr 2022 Apr 2022 Apr 2022 Jun 2022	Green	• The Trust is currently performing ahead of the financial plan in Q3 and is expected to deliver against the agreed year end plan. • Annual business plans were produced as part of the 2022/23 business planning round. These plans identified and included recurrent costs associated with the pandemic and were allocated to appropriate budgets. • Plans are in place to remove capacity and costs associated with the pandemic in line with planning guidance and assumptions. These are heavily reliant on

		• Identify and develop Efficiency & Productivity Programme to deliver £16.6m of cost reduction and efficiency savings.			having similar levels of Covid experienced in summer 2021 which has not been the case at times. • The Efficiency & Productivity Programme at Q3 has a current forecast of c. £12m against a target of £16.6m which is off plan due to the challenges with delivery against productivity schemes due to continued operational pressures.
Chris Thickett	We will develop a long-term financial plan in 2022/23 which outlines the steps required to enable the Trust to get back to a recurrent balanced position in the next 3 to 5 years.	• Understand ICS system allocations over next 3-5 years and implication for BHNFT. • Understand and review Barnsley demand activity over 3-5 years including projected capacity and workforce requirements. • Production of a 3–5 years financial recovery plan identifying the actions that are in the Trust's control and those that are dependant upon partners and national funding allocations.	Sep 2022 Sep 2022 Sep 2022	Amber	• Work is taking place and the Trust are engaged with the ICB strategy and financial planning conversations to inform BHNFT plans. Following further engagement with the ICS through Q4 the 3-5 years financial recovery plan will be produced.

4. Best for Place - We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health					
Lead Director	**Objectives (including key metrics to measure success)**	**Key Actions and Milestones**	**Completion Date**	**RAG Status**	**Progress Update**
Bob Kirton	We will continue to play a key role in the delivery of Barnsley Place priorities 2022/23. Delivery measured by: • Successful transition to Integrated Care Board (ICB) and new place structure. • High level Barnsley Health & Care plan metrics. • High level metrics from 2030 plan.	• Work to the national timetable for transition from Integrated Care System (ICS) to Integrate Care Board (ICB) including a new place infrastructure. • Support delivery of Barnsley Health and care plan priorities, regularly reporting progress to Board and other key forums. The plan is expected to be signed off in April 2022 and current high-level priorities include: 1. Grow our workforce (capacity, capability and resilience); 2. Strengthen our joint approach to prevention (making every contact count); 3. Improve equity of access (no wrong door); 4. Join up care and support for those with greatest need (integrated personalised care). • Support delivery of Barnsley Health and Wellbeing strategy. • Continue to support delivery of the Barnsley 2030 vision and priorities. • Ensure our work aligns with and feeds into that of our partners across the place wherever appropriate, including by being active members of the Inclusive Economy Board, Tobacco and Alcohol Control Alliances and Active in Barnsley Partnership.	July 2022 Mar 2023 Mar 2023 Mar 2023 Mar 2023	Green	• The CCG has now transitioned into the ICB and the ICB at Place board has been established and reports into the South Yorkshire ICB board. Draft governance structure arrangements have been proposed and the engagement draft of the Integrated Care Partnership Strategy has now been circulated by the ICB with opportunity for feedback from key stakeholders closing January 2023 and formal launch expected February/March 2023. The strategy and operational planning priorities will be reflected in the development of a 5 Year Joint Forward Plan which the Trust are engaged in development of with Place. • The Healthy Lives Programme and Team has undergone a post-pandemic learning and development review resulting in a number of actions, including ACT becoming an early adopter for the Trust of Care Flow Connect digital ward system, plans to build the BI capacity and a specific QUIT improvement plan and recruitment to expand the tobacco control programme. • See above under clinical effectiveness relating to Core20Plus. This is informing work across Barnsley ICB partners for each provider organisation to develop action plans that align with the BHNFT three tier one. Also work ongoing to develop the Vulnerabilities Index used through pandemic response into a something that can be used all HSC to target greatest need based on deprivation. • The Deputy Chief Executive is a member of the Barnsley 2030 goal group and leads one of the four 2030 goals, Healthy Barnsley. The trust's consultant in public health has supported the Healthy Barnsley group to explore health Barnsley 2030's role in addressing health and related inequalities. BHNFT have supported a number of Barnsley 2030 development sessions. • This continues to happen, with those specific alliances and groups being supported by both of the trust's consultants in public health.
Bob Kirton	We will act as an Anchor Institution to increase local employment and spend, reduce environmental impact and work as part of place to reduce health inequalities and improve population health. Delivery measured by: • Anchor metrics to be developed.	• Delivery of the Health Inequalities Action plan, reported quarterly to Quality & Governance Committee, including work on prevention and holistic care, targeting our services to people with the greatest need first and monitoring the Trust and wider system's activity. • Continue progress against the Trust Anchor Institution charter, reporting regularly to Board and other key forums including progress against agreed actions such as the demonstrator projects and development of further metrics.	Mar 2023	Green	• Delivery of the action plan and reporting into Q&G on its progress is ongoing. • Anchor Institution work is progressing well and supported by the trust's anchor institution network where metrics in support of the charter work will be used when appropriate. Part of this progress relates to how the trust increases support to the local economy, including working on successes of the CDC at the Glassworks with expansion MRI/CT in development. To foster local procurement any opportunities over £10k will now go to S and D postcodes first

	• Health Inequalities action plan metrics.	• Improve social mobility in the local population by supporting education and recruitment from groups at greater risk of inequalities and supporting the development of the Barnsley Health and Care Academy. • Launch the Trust's Green Plan (see below) and develop actions around air pollution, reducing waste and improving waste management, and supporting the development of more sustainable health technologies including Personal Protective Equipment (PPE). • Sharing learning with local partners and more widely to align our approach with those of other anchor institutions and by so doing develop economy of scale and greater momentum. • Delivery of further initiatives and actions set out in the high-level priorities of the Trust Objectives.			• Consultant in Public Health working with local health partners and educational institutions, including Northern College and Barnsley College, to establish the Barnsley HSC Academy and more generally improve local education, employment and professional development. Supporting the Barnsley 2030 Board and Inclusive Economy Board to commit to actions to reduced inequalities, including promoting the real living wage. • There are currently 10 QI projects with outcome measures associated with the anchor and sustainability agendas for example the sustainable waste management in anaesthesia & critical care. The team identified that adhesive sharps pad could be removed from the arterial line packs and work is ongoing to understand the full benefits from a sustainability and environmental perspective. • Reusable PPE pilots have been a success and roll out is being considered for 2023/24. Sub projects also a success, including the A&E Green actions, such as switching to reusable procedural and suture packs. • BHNFT chairs the Barnsley Health Equity Group which is promoting the use of the Trust's three tier framework for improving public health and reducing inequalities across health and wider partners. This includes work to develop anchor institution principles and an anchor network. BHNFT is awaiting BMBC to start an exec-level group to pursue the Barnsley anchor network.

Continued on next page

5. Best Partner - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways					
Lead Director	**Objectives (including key metrics to measure success)**	**Key Actions and Milestones**	**Completion Date**	**RAG Status**	**Progress Update**
Richard Jenkins, Bob Kirton	We will further improve services across our region and meet the priorities set out in the Government White Paper on Integrating Care by continuing to work with partners at system level in 2022/23. Delivery measured by: • SYB Acute Federation milestones and metrics. • SY ICS metrics tbc.	• Contribute to the Integrated Care Board 5-year system plan priorities and governance set out in the Government White Paper on Integrating Care development (ICB priorities to follow date tbc). • Support implementation of new South Yorkshire and Bassetlaw Acute Federation (SYBAF) governance and agreed priorities (further details to follow once agreed). • Continued support of existing workstreams with regular updates to Board and other key forums including hosted networks and the SYB pathology network. • Further develop our investment in partnership roles and capacity, including through the public health and health intelligence function, and support this approach in other places in the Integrated Care Board (ICB). • Work in collaboration with system partners and support system plans to achieve national planning priorities including reduction of long patient waits at a system level contributing to the delivery of 30% more elective activity by 2024/25 than before the pandemic through the South Yorkshire elective hubs. • We will review our relationship with The Rotherham Foundation Trust, to evaluate work to date and agree risks and opportunities for partnership working.	Mar 2023 Apr 2022 Mar 2023 Mar 2023 Mar 2023 Mar 2023	Green	• The engagement draft of the Integrated Care Partnership Strategy has now been circulated by the ICB with opportunity for feedback from key stakeholders closing January 2023. The four shared outcomes outlined are: best start in life for children & young people, living healthier & longer lives and improved wellbeing for greatest need, safe strong & vibrant communities and people with the skills & resources they need to thrive. Formal launch is expected February/March 2023. The strategy and operational planning priorities will be reflected in the development of a 5 Year Joint Forward Plan which the Trust are engaged in development of with Place • Acute Federation Delivery reports are shared through the Acute Federation board on a quarterly basis and the clinical strategy is in development with an expected completion date of April 2023 • The final draft of the pathology partnership agreement has now been signed off and a joint business case for a joint integrated pathology IT system has gone to all Boards December to January for agreement and we are awaiting an updated programme plan. The Barnsley/Rotherham gastroenterology partnership is in place with a shared rota and prioritised support to Rotherham in hours for Gastrointestinal bleeds. Software packages that support integrated working including a shared booking system and endoscopy systems are in place. • The Trust continues to engage with partner providers to support system plans, utilising capacity within the Trust and at other sites to reduce long waits as a system. • The Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust have formalised their partnership through the substantive appointment of a Joint Chief Executive, with both trusts committing to build on the close relationship they have formed in recent years. A delivery plan is in development for 2023/24.
Richard Jenkins, Bob Kirton	We will work further on developing and agreeing our partnership models and continue work with local Trusts to sustain local services for the people of Barnsley and beyond. Delivery measured by: • TBC.	• Undertake assessment of current partnership portfolio including full analysis of existing agreements and assessment of other services to determine where partnerships may improve sustainability. • Development session with Trust Board to present partnership portfolio assessment and agree future partnership prioritisation plan.	Jul 2022 Mar 2023	Amber	• Sustainability reviews will be taken forward with services in Q4 and a baseline position discussed with teams at the March 2023 performance reviews. Following this a workshop will take place to develop a strategic approach to inform monitored delivery plans. • Further work to be undertaken on partnerships and the Trust's approach in 2023/24.

6. Best for Planet - We will build on our sustainability work to date and reduce our impact on the environment					
Lead Director	**Objectives (including key metrics to measure success)**	**Key Actions and Milestones**	**Completion Date**	**RAG Status**	**Progress Update**
Bob Kirton/ Lorraine Christopher	We will build on existing work and exceed national expectations through the delivery of the Trust's Green Plan, the Active Travel Plan and the formation of a new Decarbonisation Plan. Delivery measured by: • Decarbonisation scheme delivered including Roadmap in place for net-zero targets. – *On track* • Increased recycling across the Trust including a further 100 plus recycling bins. - *Complete* • 10 Electric Vehicle (EV) charging points for staff and 2 for the public.- *Complete*	• Deliver the Decarbonisation (Salix) capital scheme following successful funding award of £3.7m including but not limited to: ○ Air source heat pumps to the outer blocks; ○ Improved building fabric; ○ Electrical transformer upgrade. ○ Building management system upgrades;	Mar 2023	Green	• Decarbonation scheme is progressing, and we are on target to complete by the end of the financial year. ○ Air Source Heat Pumps (ASHP): Staff from outer blocks have been decanted and relocated to Gateway Plaza. Installation of new mechanical heating system has commenced with expected completion by 31/03/23 and final commissioning works to be completed by April 2023 ○ Complete. Building fabric: Education Centre and Z Block ground floor windows replaced. New roofs have been installed on outer blocks ○ Transformer upgrade: Installation of the new transfer is scheduled to take place on 22nd January 2023. Full installation is expected to be completed by 31/03/23.
		• Develop a new Decarbonisation Plan to provide a roadmap to support the delivery of net-zero targets for future years.	Mar 2023		• Complete. Decarbonisation Plan: The cost of developing the plan was fully funded by a successful grant bid of £46k. New Heat Decarbonisation Plan was completed and presented at the Sustainability Group meeting on 18/08/22 and added to the note added to Chairs Log for ET.
		• Trust Green Plan communicated out to all key stakeholders and delivery of any other agreed priorities including but not limited to: ○ Increase recycling opportunities with a further 100 plus mixed waste recycling bins across the Trust; ○ New cycling hub to be installed at front of the site providing facilities for 30 plus bikes which will also include electric bike charging points and repair stand; ○ Consideration of re-useable PPE transitioning from single-use where appropriate; ○ Plan to re-upholster, re-use and recycle furniture to ensure quality, reduce carbon and landfill impact; ○ Work further with departments on local sustainability initiatives.	Mar 2023		• Delivery against Trust green plan against a number of initiatives delivering agreed priorities including: ○ Recycling bins: Recycled bins have been rolled out in all areas of the Hospital ○ Cycling Hub Installed outside O Block ○ Reusable PPE: Following successful trials, a reusable PPE roll out is being considered for 2023/24. ○ Furniture up-cycling: Supplier approved and now awaiting projects from departments ○ Sustainability initiatives: A number of initiatives currently being rolled out including replacing single use suture packs with reusable in ED. New paper hand towel system, new bins made in Barnsley, clinical waste bins made from recycled materials. Removed over 550k single use plastic following switch to paper with paper cup use also down by 200k. Following the decision to remove Desflurane anaesthetic gas which is one of the most pollutant, the Trust will reduce carbon emissions by 161 tonnes annually. The above initiatives are supporting local businesses, creating local employment and benefit the regional economy.
		• Implementation of a new Active Travel Plan to reduce car use and increase staff cycling and walking to work.	Mar 2023		• Active Travel Plan: Recently inducted on a new NHS programme known as Step Up a Gear'. This will be led by experts to support Trust's to develop and implement active travel initiatives. This programme will feed into the new Travel Plan.
		• Review and introduce new car parking permit options in alignment with our Green and Active Travel Plans.	Mar 2023		• Car Parking Permits: A range of new permits in place
		• Provide access to further EV charging points from 10 to 20 for staff and 2 for public use.	Jun 2022		• EV Charging Points: 10 new staff and 2 public charging points have been installed now bringing the total to 22. 75% of lease vehicles are electric, hybrid or plug-in hybrid, 21% petrol, 4% diesel.
		• Progress against the above will be monitored and reported through the Sustainability and Capital Monitoring Groups.	Mar 2023		• Governance: Updates are provided via Chairs Log for ET and quarterly updates to the F&P committee and Trust Board via the quarterly strategy progress reports. (

3.3. Quarterly Mortality Report

For Assurance

Presented by Simon Enright

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/3.3

SUBJECT:	**MORTALITY REPORT**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Alex Walton, Information Analyst, Amy Sylvester PSQI Assistant, Tracey Radnall, Head of Patient Safety & QI				
SPONSORED BY:	Dr Simon Enright, Medical Director				
PRESENTED BY:	Dr Simon Enright, Medical Director				

STRATEGIC CONTEXT

Trust Objectives 2022/23: The Trust has a quality target to keep the overall Hospital Standardised Mortality Ratio (HSMR) within the statistically set limits for our hospital (Statistically set at ≥77.9 and ≤136.2).

EXECUTIVE SUMMARY

Crude mortality: Year to date is 26.42

SHMI: The latest rolling month to July 2022 is 100.66 (classified as expected).

HSMR: Latest data from CHKS is to September 2022 and reports 116.22 for the preceding 12-month period (classified as within limits).

Learning from Deaths: All deaths are reviewed by the Medical Examiner Service and all requested SJR's have been completed.

External Informatics: CHKS provide the Mortality Profiling services for BHNFT including variances across the SHMI, and the HSMR. CHKS have a 12month extension to December 2023 and a new tender process will re-commence in Q2 of 2023.

ReSPECT: ET approved a paper on 12/10/2022 for BHNFT to use the national Recommended Summary Plan for Emergency Care and Treatment form (ReSPECT) instead of the Do Not Attempt Resuscitation (DNACPR) form.
Subsequently a Respect Core Delivery Group and Barnsley RESPECT Partnership Steering group - Adults and CYP – has been implemented in January 2023 with plans for BHNFT to be the first to implement in March 2023.

RECOMMENDATIONS

The Board of Directors is asked to review and receive the report.

Statistical data correct as of 31 December 2022

The Mortality Overview Group (MOG) action plan is reviewed at the Learning from Mortality Group and the Chairs Log supplements the Mortality Report to CEG which in turn reports to Q&G.

MORTALITY STATISTICS

1a: Summary Table

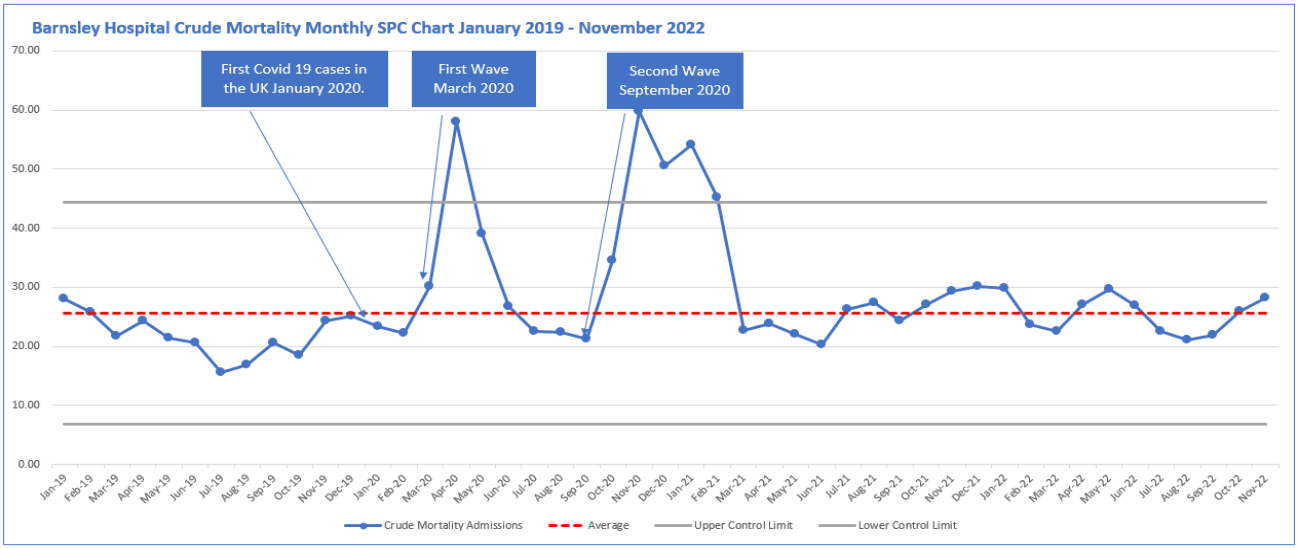
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Admissions	4122	4049	3828	3677	3650	3701	3948	3823	4073	3938	3914	4117	4281	3781
Deaths (HSMR)	80	86	57	45	54	73	91	65	54	56	56			
Expected Deaths (HSMR)	66	78	53	46	59	59	66	45	39	42	46			
Covid Deaths	34	18	28	20	28	22	20	5	21	10	8	13	11	18
HSMR 12 Month Rolling	122.17	118.80	115.52	112.08	112.19	108.14	111.05	113.41	115.30	116.83	116.22			
SHMI	101.77	103.29	104.06	104.67	102.22	100.81	100.88	101.43	100.66	100.30				

1b: Crude Mortality Rate per 1000 Admissions: Overall year to date is 26.42

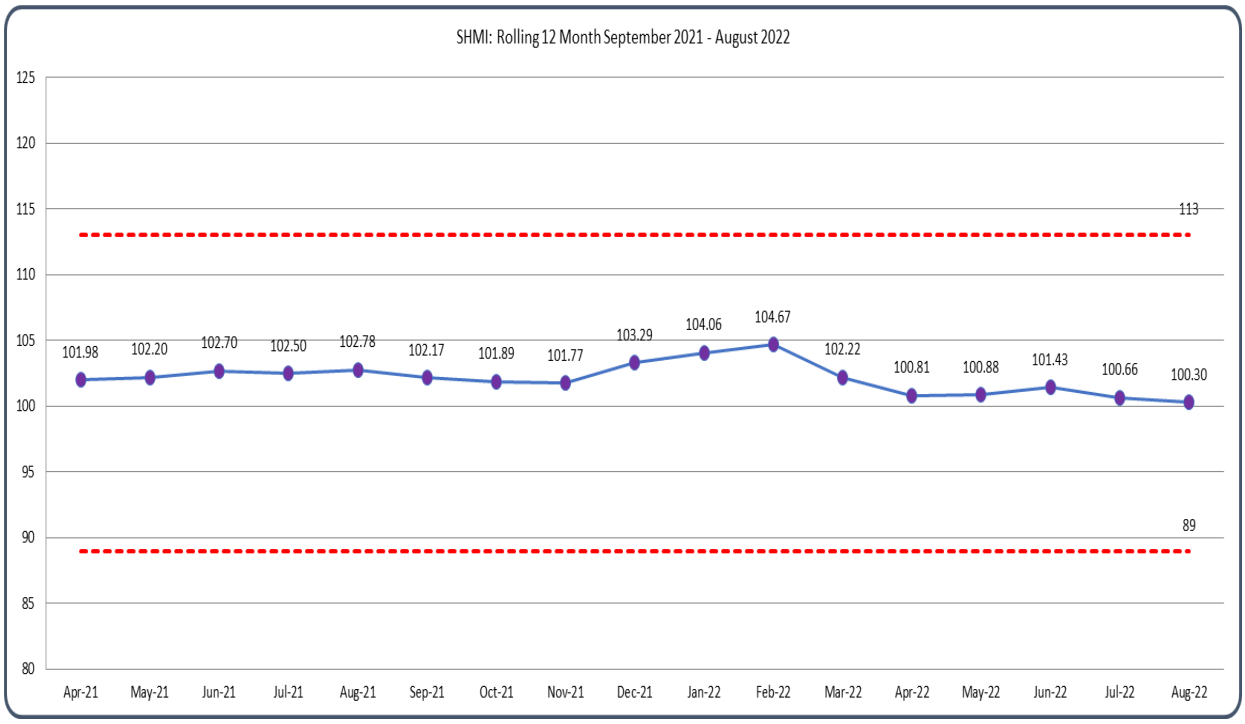
Crude, weekend and weekday mortality is calculated using a rate per 1000 admissions:
There is no national mandated crude mortality indicator and it is not an externally reported metric but was initiated in 2017 in response to the "NHS weekend effect" There is currently no significant difference between weekend, weekday and overall crude mortality in the year to date numbers for BHNFT. ED Crude Mortality demonstrates the correlation between mortality and wait times.

	Overall Crude Mortality			Weekend Crude Mortality			Weekday Crude Mortality		
Year	All Deaths	All Admissions	Crude Mortality *(All Deaths divided by All Admissions multiplied by 1000)*	Weekend Deaths	Weekend Admissions	Weekend Crude Mortality *(Patients Admitted on a weekend that went on to die / Weekend Admissions)*	Weekday Deaths	Weekday Admission	Weekday Crude Mortality *(Patients admitted on a weekday that went on to die/Weekday Admissions)*
2016/17	969	41516	23.29	271	11960	23.83	698	29556	23.62
2017/18	1066	43224	24.73	292	12872	21.36	774	30352	25.50
2018/19	1067	45855	23.26	316	12843	20.95	751	33012	22.75
2019/20	1049	48224	21.68	278	14136	18.25	771	34088	22.62
2020/21	1386	37133	37.46	416	9729	26.62	970	27404	35.40
2021/22	1188	46345	25.63	343.00	10481	32.73	845	35864	23.56
2022 to date	940	35576	26.42	284.00	10775	26.36	656	24801	26.45

In Month overall crude mortality trend since Jan 2019:



1c: SUMMARY HOSPITAL-BASED MORTALITY INDICATOR (SHMI): 100.3 to Aug 2022.



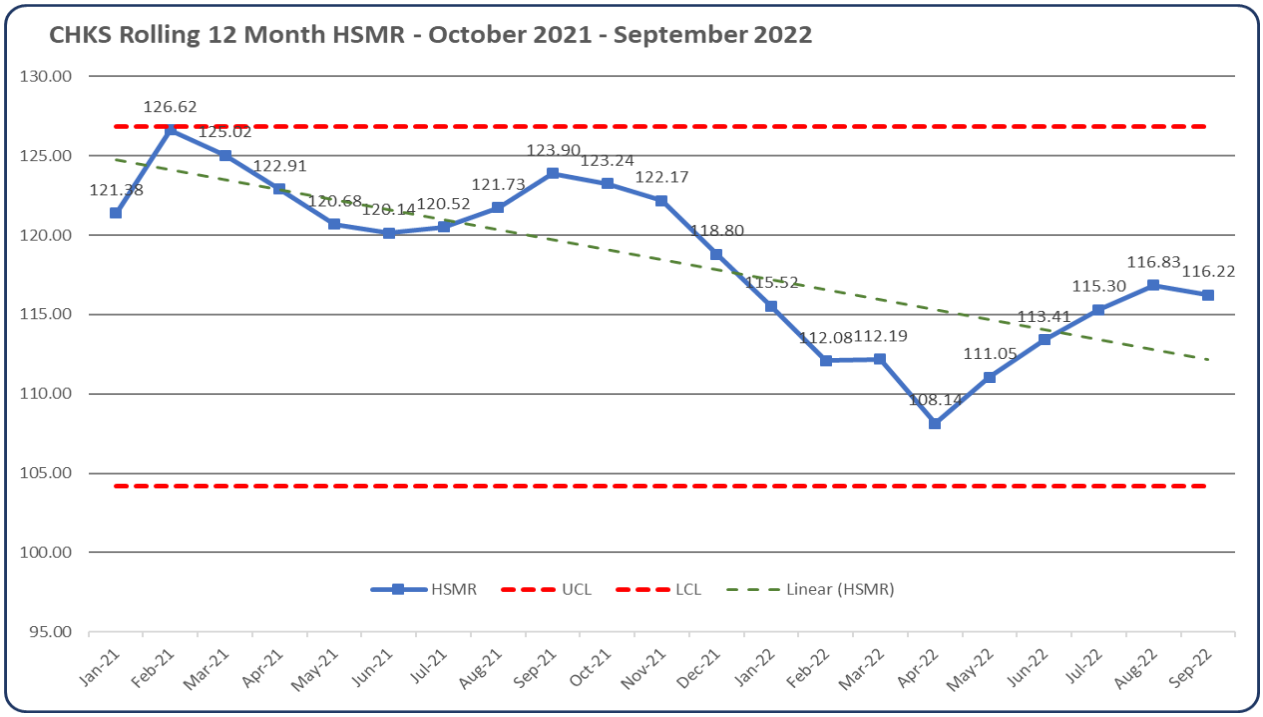
Latest data is 2022/23 August 2022 is 100.30. The SHMI data at BHNFT is banded 'as expected' and within the upper and lower control limits set by NHS Digital (Lower: 0.89, Upper: 1.16).

- The SHMI is a ratio of the observed number of all in-hospital deaths and deaths up to 30 days post-acute trust discharge against the number of expected deaths.
- Any COVID-19 activity including any recorded on the death certificate is excluded from the SHMI (as of July 2020).
- The SHMI is not influenced by palliative care coding.

1d: HOSPITAL STANDARDISED MORTALITY RATIO (HSMR): 116.22

The 12-month rolling HSMR to September 2022 is 116.22 and within limits set by the external analytics company.

- The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 out of 260 Clinical Classification System (CCS) groups. This accounts for 83% of deaths.
- Only Covid-19 activity recorded in the first finished consultant episode is excluded from the HSMR
- The HSMR is sensitive to Specialist Palliative Care (SPC) coding. The higher percentage of deaths coded with specialist palliative care the lower the HSMR will be.



	Rolling 12 Month Benchmark Similar Profile Peer Group October 2021 - September 2022	HSMR
The matched peer is revised by CHKs in consideration of any changes in the comparison organisations and has been accepted by the Learning from Deaths Group	South Tyneside and Sunderland NHS Foundation Trust	130.75
	Harrogate and District NHS Foundation Trust	117.75
	Sherwood Forest Hospitals NHS Foundation Trust	121.37
	Barnsley Hospital NHS Foundation Trust	**116.22**
	Airedale NHS Foundation Trust	109.64
	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	109.57
	James Paget University Hospitals NHS Foundation Trust	107.60
	Chesterfield Royal Hospital NHS Foundation Trust	103.66
	Mid Cheshire Hospitals NHS Foundation Trust	101.41
	The Rotherham NHS Foundation Trust	98.39
	Warrington and Halton Hospitals NHS Foundation Trust	91.93

1e: The variance between the HSMR and SHMI:

Both the SHMI and HSMR are used for trend analysis. The ME escalations, SJR and escalations for review to PSP remain the most reliable assurance mechanism regarding patient care.

The SHMI currently reflects a good position for BHNFT however the HSMR is adversely affected by:

- Lower percentage of deaths coded with specialist palliative care (25% at BHNFT compared to peers for example 43% at TRNFT) adversely affecting the relative risk of death calculation

- As it currently stands Covid deaths are not included within HSMR if it is the primary diagnosis, but any patients with Covid19 in the secondary or any other position will be included. This is a particular issue for BHNFT because of the large number of Covid deaths without Covid in a primary position.

- Covid positive community cases are not being coded due to short multiple episodes and fragmented digital notes making a definitive coding source difficult for coders to identify.

- Short and multiple finished consultant episodes reduce the opportunity to code an accurate diagnosis.

- Due to the impact of Covid on the HSMR during 2020-2021 the statistically expected number of deaths is likely to carry some adverse variations which will continue into 23/24.

Work is ongoing with the information team, coding team, IPC and palliative care team to address the identified HSMR issues including:

- Reducing the number of false FCE's generated. The data quality team provide data quality checks which are shared with the areas for them to retrospectively amend any false FCE's. This is an ongoing programme of raising awareness by the data quality team and training by clinical systems.

- Providing the coding team with reliable sources from which to code Covid positive test results whilst adhering to the coding standards. This will include information from the IPC team

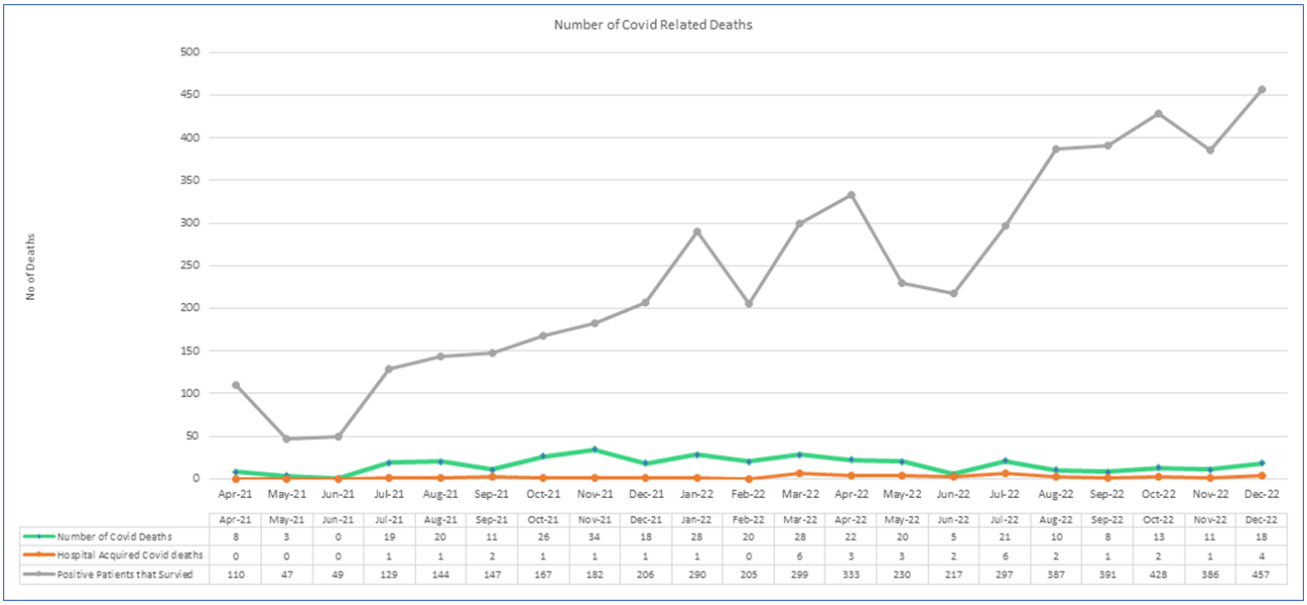
- Reviewing the Specialist Palliative Care Coding policy to ensure all opportunities to code specialist palliative care available to the coding department.

- Reviewing all patients (147 identified as potentials) coded with non-specialist care with the team to identify any potential for SPC coding

Comparisons and Limitations of the statistics are detailed in **Section 2g**.

1f: Covid-19 related deaths to December 2022.

At the time of this report the data is still being validated and there may be changes to the final data set.



The definition of Hospital acquired Covid is tested positive >15days**.**
Routine testing for Covid stopped on 31st August 2022.

In December 0.8% (4) of patients who tested positive for Covid died with hospital acquired Covid, compared to 0.2% (1) in November and 0.4% 2) in October

Three incidents reported as definite HA covid-19 resulting in death were patients on ward 20. Stage 1 and 2 of duty of candour have been completed. The RCAs have been completed and are awaiting review at the IPC group and the findings of the investigation will then be shared.

One incident of definite HA covid-19 occurred on ward 33. Stage 1 and stage 2 duty of candour have been completed. This incident is also the subject of an SI investigation and the HA covid-19 is part of the terms of reference for the SI which is due for completion 08/03/2023

One patient has Covid-19 in part one of the death certificate**.**

1g: Coding:

The coding team are actively engaged in reviewing local coding policies to ensure all opportunities to support improvements in the HSMR are taken.

Clinical Coding receives the Official National Code changes including standards and guidance every April from the WHO. Any new changes to coding practice or any new codes that might have an impact on the Trust's mortality statistics are communicated to MOG and will form part of the Coding report to the LfM group.

1h: External Informatics – Contract renewal December 2022

The Trust currently benefits from external informatics support from CHKS https://www.chks.co.uk/
A tender process in accordance with BHNFT policy was undertaken in November and December 2022 with one company shortlisted for panel review. A successful bid was not received and the existing contract holders are being extended for 12-months. A tender process will start again in the summer of 2023.

2: LEARNING FROM DEATHS

GOVERNANCE: Learning continues to be discussed at the weekly mortality overview group with escalation for SJR's and to the Patient Safety Panel if required. The MOG action log is reviewed at LfM and where appropriate in the chairs log to CEG

2a: Sharing Learning

Learning from Deaths Bulletins Q3	Edition 71 Regulation 28 Edition 72 DNACPR Edition 73 Frailty Edition 74 Head Injury in the Elderly Edition 75 Regulation 28 (final guidance) Edition 76 DNACPR Handovers Edition 77 Head Injury Edition 78 Good Record Keeping Edition 79 Learning regarding 'Metastatic Disease' in Myeloma
CBU speciality reports	CBU speciality level HSMR reports are now available on IRIS
Mental Health SJR Report	The Mental Health SJR report is shared quarterly with the Mental Health Steering Group
Learning Disabilities & Autism SJR Report	Learning Disabilities & Autism report is shared quarterly with the safeguarding lead.
End of Life SJR findings report	This report shares the findings of End of Life Care within mortality reviews on deceased patients where a Structured Judgment Review was requested.
Escalations from the SJR's	Any identified periods of poor care in SJR's are escalated by Mortality Overview Group to Patient Safety Panel.
Thematic review of escalations to the PSP	Thematic review of escalations to the PSP are reported on bi-annually to the LfMG and shared with the relevant governance group such the deteriorating patient group, medicines management group and End of Life Group.

2b Compliance:

LEARNING SOURCE	ACTIONS COMPLIANCE & COMMENTS		
	October 2022	**November 2022**	**December 2022**
Medical Examiner (ME)Scrutiny	• 100% reviewed (114)	• 100% reviewed (115)	• 100% reviewed (159)
ME Feedback	• 17 compliments passed to the clinical teams	• 13 compliments passed to the clinical teams • 1 concern raised at the time of the ME call were actioned by the appropriate lead nurse or consultant.	• 17 compliments passed to the clinical teams • 2 concern raised at the time of the ME call were actioned by the appropriate lead nurse or consultant.
MEO referral to PALS	• 1	• 0	• 1
ME Escalations to MOG	• 20	• 17	• 25
ME Escalations due to a wait time in ED>4hours	• 0 *Any wait >12 hours is recorded on Datix and the investigation supported by the clinical governance team*	• 0 *Any wait >12 hours is recorded on Datix and the investigation supported by the clinical governance team*	• 0 *Any wait >12 hours is recorded on Datix and the investigation supported by the clinical governance team*
Mortality Overview Group (MOG) Actions	• 8 SJR's requested, all awaiting return (within 20 Working day timeframe) • Action log reviewed and future learning bulletins agreed. • 18 MOG actions completed • 15 case notes reviewed for coding (Sepsis and Cardiac Arrest)	• 10 SJR's requested; - 6 returned with no further escalation required. - 4 awaiting return (within 20 Working day timeframe) • Action log reviewed and future learning bulletins agreed. • 25 MOG actions completed • 8 case notes reviewed for coding (Cardiac Arrest)	• 8 SJR's requested; - 1 returned with no further escalation required. - 7 awaiting return (within 20 Working day timeframe) • Action log reviewed and future learning bulletins agreed. • 13 MOG actions completed • 1 case notes reviewed for coding (Cardiac Arrest)
SJR Compliance	• 100%	• 100%	• 100%
MOG Escalations to the Patient Safety Panel	• 2	• 0	• 0
PSP Decisions	• EoL Group / Report • Datix/Local Investigation	• NA	• NA
Learning bulletins	• 2 • 3 September	• 2	• 2
Learning from Mortality Group	• Chairs log will be shared to the CEG: 21 September 2022 • Next meeting: 2 November 2022	• Chairs log (shared to the CEG): 16 November 2022 • Next meeting: 11 January 2023	• Chairs log (shared to the CEG): 18 January 2022 • Next meeting: 8 March 2023

2c: Improvement Projects Q3

October – December 2022	
Generic ED Consultant Code & False FCE	Risk 2696 has ongoing monitoring actions in place. Assurance will be provided by the information analysts in a report to be tabled monthly at CEG: 1.Ward clerks to receive training and update refresher training from clinical systems - training to be reported to the CEG monthly for assurance 2.Head of Information to ensure monthly reports on the number of false FCE's occurring are run and presented to the CEG for assurance.
Adverse Factors affecting HSMR	Discussions and meetings continue around Z51.5 coding (specialist palliative care and specialist supportive care). SJRs relating the EOL have been shared. There is good engagement and willingness by all involved to improve the coding sources for this and better reflect the care delivered to end of life patients. The Clinical Nurse Specialist in Palliative Care and the Macmillan Trust Lead Cancer Nurse are reviewing how the activity can be captured and shared in a format suitable for coders to identify. Reviewing all patients (147 identified as potentials) coded with non-specialist care with the team to identify any potential for SPC coding The local policy for Z51.5 coding will also be reviewed by the team
Frailty	Although frailty is a leading cause of death in older people, it is often not recognised nor considered at end of life. Late recognition can impede both choice of place of care and patient-centred decisions. Both lead to inappropriate life-saving interventions and to under-treatment of palliative symptoms and concerns. Transitions into hospital in the last year of life, and hospital deaths, are common for older people living with frailty. To raise awareness the AMD for Mortality carried out a teaching session with the doctors in training. Work is being undertaken to introduce and embed the use of the Rockwood Clinical Frailty Scale. This a tool used to estimate an individual's degree of frailty on a scale of 1 (very fit) to 9 (terminally ill). Patients who score a 5 or higher are considered frail and likely to be in the last year of life. Work has been started to on the coding of frailty to be more consistent with the coding practices within the peer group. A learning from deaths bulletin has been shared on the subject.
DNACPR/ ReSPECT Communication	A learning session on DNACPR/ReSPECT communication is planned for February. Jon Goodinson and Dr Orme are going to formulate a difficult

	communication scenario with both OPD and IP care, presenting cases where early decisions and DNACPR discussions could have saved unnecessary distress.
ReSPECT	Barnsley Hospital NHS Foundation Trust is planning to use the Recommended Summary Plan for Emergency Care and Treatment form (ReSPECT) instead of the Do Not Attempt Resuscitation (DNACPR) form. ReSPECT is a national plan whereby Patient preferences and clinical recommendations are discussed and recorded on a non-legally binding form which can be reviewed and adapted if circumstances change. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop. An engagement process started with the medical staff via a survey monkey to ascertain the level of support required to introduce ReSPECT. There is a wide range of resources available through the Hub from the Resuscitation council and ReSPECT has been incorporated into the resuscitation training. A policy has been approved at Board to support ReSPECT. Subsequently a Respect Core Delivery Group and Barnsley RESPECT Partnership Steering group - Adults and CYP – has been implemented in January 2023 with plans for BHNFT to be the first to implement in March 2023. Rotherham have also joined the group. BHNFT has shared resources including policy, training tiers and learning materials with the wider partnership group and has an active role in both groups. The communications team are working with the Resus Council to produce posters that are relevant to the population of Barnsley.
Medical Examiner Service Quality Improvement Project	The ME service is handing over the process for obtaining timely MCCD to the general office. Discussions are taking place about how to improve on this and how to ensure consultant involvement in the causes documented. The ME service continues work on the Quality Improvement project with the Patient Relatives Service and Barnsley's Registry Office. This project aims to avoid any delay in the issue of the MCCD and promote smoother working practices.
First Finished Consultant Episodes (FFCE)	Based the experiences of junior doctors who noted the recording of FCE's at this Trust results in patients shown under consultants whom they may never see, a proposal was put forward to look at the work carried out in Rotherham and Doncaster on this issue. Meetings have taken place and mortality representatives from Rotherham and Barnsley have agreed to continue to meet quarterly to share learning and processes. The Information and coding team are reviewing if and how the processes can be implemented at BHNFT
Paediatric plans for Quality Improvement Project	The plans for Quality Improvement Project presented to the LfM group to look into the M&M Process for child deaths to enable sharing of learning has progressed and the team were congratulated on the format of their report which focussed on each individual experience.

2d: Medical Examiner Service:

Summary of Quarter 3

The contingency plans enacted by the service following unexpected absences during the summer have proved effective and the service is now at 94% compliance with 100% compliance expected again in November 2022.

The Service have introduced a triage process for periods of high activity which includes:

- Any concerns raised by relatives
- Any concerns raised by the qualified attending practitioner
- Any concerns from the medical or nursing team
- Any relevant datixes
- Any that might require referral to the coroner
- Any concerns from any other sources

MEO's have attended several more GP practices to speak with practice managers and admin staff to explain the ME service and referral process. These practices are very enthusiastic and keen to get on board with the service.

The QI project with Patient relatives service and Barnsley registry office is progressing well. This aims to avoid any delay in the issue of the MCCD and promote smoother working practices.
The ME's are no longer undertaking the Coroners referrals and letters requested by the coroner. These are now completed by the parent team rather than the ME office.
ME recruitment is taking place with an interview date scheduled for the 1st February 2023

2e: Regional update:

No regional meeting since September 2022

2f: National Updates:

The national updates in Q3 include:

- Implement appropriate out-of-hours arrangements
- Preparing for statutory status
- Good Practice Series – antimicrobial resistance and out-of-hours
- Reviewing GP patient records
- Medical Indemnity
- Template information for members of the public
- Implementation in Wales
- Quarterly reporting in England
- Patient Safety Incident Response Framework in England
- Training and events
- Contact details
- Preparing for statutory status

Medical examiner offices should work with their regional medical examiner to identify and implement appropriate out-of-hours arrangements. In addition, medical examiners should consult stakeholders with an interest in out-of-hours provision, both when devising out-of-hours arrangements and on an ongoing basis to ensure out-of-hours arrangements are optimal. Examples include local faith groups and representatives of bereaved parents, particularly for providers of specialist healthcare for children.

The service at BHNFT has not identified any current need for an out of hours service but this will be reviewed as the community roll out progresses.

Preparing for statutory status and identify options for all local healthcare providers to share patient records efficiently with them. Medical examiner offices must build relationships with all healthcare providers and stakeholders in their area, and agree local processes.
BHNFT are well placed for when the service becomes statutory with MEO's having attended several more GP practices to speak with practice managers and admin staff to explain the ME service and referral process. These practices are very enthusiastic and keen to get on board with the service. The hosted service at BHNFT is delivering on the key areas and is ready for the statutory system.

The October 22 edition of the National Medical Examiner bulletin can be found here
https://www.rcpath.org/profession/medical-examiners/good-practice-series.html

The November 22 edition of the National Medical Examiner bulletin can be found here
https://www.england.nhs.uk/long-read/national-medical-examiner-update/
https://www.rcpath.org/profession/medical-examiners/good-practice-series.html

The December 22 edition of the National Medical Examiner bulletin can be found here
https://www.england.nhs.uk/publication/national-medical-examiner-updates/

2g Hospital Mortality Measures

Comparisons and Limitations

At BHNFT we use the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) to measure whether the mortality rate at a hospital is higher or lower than expected. A high or low HSMR or SHMI is not indicative of poor or good care but it can be a signal that further investigation is required.

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 out of 260 Clinical Classification System (CCS) groups. This accounts for 83% of deaths.

The SHMI is a ratio of the observed number of in-hospital deaths and deaths up to 30 days post-acute trust discharge against the number of expected deaths. The SHMI excludes Covid 19 including if Covid 19 is on the death certification.

HSMR only excludes Covid if it is in the primary diagnostic position. Work to ensure the coding team have appropriate sources to code Covid Activity is on going

The HSMR is sensitive to specialist palliative care coding and it is recognised the majority of palliative care at BHNFT is coded as non-specialist. Non-specialist palliative care does not influence the expected death model. The work on this is ongoing.

The SHMI is not influenced by specialist palliative care coding excludes Covid as there is no recognised statistical modelling as a predictor of death. It is not designed for and should not be used for peer comparisons. Although the admitting diagnosis is the primary driver, including 100 percent of deaths mean the demographics and deprivation within local population are better reflected.

Common Features

Both of the measures feature primary determinants for the risk of death;
Age (though numbers of groups vary), Admission type (elective or non-elective), Diagnosis (numbers of groups vary, but all now use CCS1 as basis), Sex (M/F), Comorbidity (albeit different methods).

None of the reported statistics are based on death certification data but instead are based on the ***primary diagnosis in the first episode of care***. If this is a ‘symptom’ or ‘sign’ then the second episode of care is used.

A sign or symptom has a low risk of death and so if a patient is admitted with a headache and then goes onto to die, this will adversely affect the mortality statistic. If, however the patient is admitted with a headache due to a probable stroke with a history of previous strokes, dementia and type 2 diabetes, with an advanced care plan and established palliative therapies, this will more accurately reflect the risk of death.

Accurate record keeping with clarity on the working diagnosis – recorded as probable, not query in the patient’s notes- is essential if the statistics are to be reliable

Common limitations of all models

The changing demographic of the population is not accounted for in the statistical modelling. Frailty is a clinical diagnosis but maps as a sign and symptom code in HSMR and in the SHMI maps to a different group to that in the HSMR.

A lack of information on severity represents a major limitation of all risk-adjusted mortality models, particularly at individual patient level. In using any of the models at trust level, the implied assumption is that differences in each condition's severity 'average out', and/or that thresholds for admission in terms of severity, are the same across all hospitals. The user needs to be aware that, in the context of their particular analysis, this assumption about severity may or may not be reasonable.

To be confident of a rate (to within 10 percentage points) approximately 1,000 deaths must be included in the dataset – BHNFT has an average above this but the degree of confidence in the underlying rate is less than a larger hospital with more deaths. For this reason, mortality rates should never be relied upon as an 'early warning' on their own and should always be presented with correctly calculated confidence intervals.

Further information on the statistics can be found Corporate - Patient Safety Education (trent.nhs.uk) and a presentation Mortality metrics overview (vimeo.com)

3.4. Maternity Services Board Measures Minimum Data Set : Sarah Collier-Hield in attendance

For Assurance

Presented by Jackie Murphy

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/3.4i

SUBJECT:	**MATERNITY SERVICES BOARD MEASURES MINIMUM DATA SET**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	□
	For review	√		*Governance*	√
	For information	√		*Strategy*	
PREPARED BY:	Maternity Governance Team				
SPONSORED BY:	Jackie Murphy, Director of Nursing & Quality				
PRESENTED BY:	Sara Collier-Hield, Head of Midwifery				

STRATEGIC CONTEXT

This report contains the minimum data set for maternity services which must be submitted to the Board on a monthly basis.

EXECUTIVE SUMMARY

In the reporting period of December 2022:

- 2 cases were notified to PMRT.
- 0 new cases were referred to HSIB.
- 0 new cases were declared as HLR/SIs
- There are three ongoing HLRs and 2 ongoing SI's
- 10 incidents were graded as moderate harm or above, duty of candour was completed in all cases.

CNST- The declaration form and accompanying presentation were presented on 5 January 2023. Approval was given for the Chief Executive and Place Director to sign off full compliance for the 10 safety actions. The submission deadline to NHSR is 12 noon Thursday 2nd February 2023. The paper and presentation are retrospectively shared with Quality and Governance committee today.

RECOMMENDATION(S)

The Board of Directors is asked to review the maternity minimum data set on a monthly basis to maintain oversight of Barnsley maternity services.

1. Introduction and overview (Appendix A)

This report will provide monthly oversight of perinatal clinical quality as per the minimum required dataset, ensuring a transparent and proactive approach to Maternity safety across Barnsley Hospital NHS Foundation Trust. An introduction to Continuity of Carer, Clinical Negligence Scheme, Ockenden and CQC preparation is provided for context and information. Overall the report intends to provide assurance surrounding any identified issues, themes, and trends to demonstrate an embedded culture of continuous improvement.

2. Details of perinatal deaths, Healthcare Safety Investigation Branch (HSIB) cases and all incidents graded as moderate harm or above (Appendix B, C and D)

2.1 Perinatal Mortality REVIEW Tool (PMRT) (Appendix B) and HSIB/SI/HLR Reports (Appendix C)

The thematic issues identified from PMRT and/or HSIB/SI/HLR cases from the last six months are:

- Mothers who live with family members who smoke were not offered referral to smoking cessation services
- Fetal heart rate monitoring in established labour was not carried out in line with guidance
- High-risk women must have an obstetric review following booking and a clear plan of care will be documented.

All themes are added to mandatory training for staff. The action plans have been produced and completed.

There were no new cases reported to HSIB in December. There are no ongoing cases currently being investigated by HSIB.

There were no new HLR's or SI's declared this month. There are three ongoing HLR's and two ongoing SI's (of the latter; one is a maternity case, the other gynaecology).

2.2 Incidents graded moderate harm or above (Appendix D)

For quarter three, the top themes for moderate harms are Term admissions to the Neonatal Unit (NNU) and Postnatal readmission of the mother to the unit. Actions have been undertaken to reduce the postnatal readmissions, including revising the hypertension guideline to ensure the mother's blood pressure is stable before discharge home. There were no postnatal readmissions in December. The plan is to include the changes in the induction training for new doctors in February 2023.

Of the ten moderate harms and above in December, there was one admission to ICU following an antenatal stillbirth (this is recorded as one moderate and one severe harm). The duty of candour process has been followed and the care has been discussed at the Weekly Incident Review Meeting, no immediate safety concerns have been identified. A full review will take place via the PMRT process. Staff involved have been supported and a debrief held.

There were seven term neonates admitted to the NNU in December. The primary reason for admission, is for the management of respiratory problems requiring airway support. Since

April 2022, five of the seventy-two term admissions to the unit have been categorised as avoidable admissions. No themes have been identified from these cases.

3. Training Compliance

3.1 Mandatory Training (Appendix E)

In order to improve safeguarding training and supervision compliance uptake is now reviewed monthly. Maternity services are working with the safeguarding team on processes to improve the recording of training, understanding that individual compliance is over a three-year period.

The compliance with Infection control level 2 training has decreased. However, this is now covered within mandatory training as from January, ensuring compliance will increase.

3.2 PROMPT (Appendix E)

The training plan recommences in January 2023.

3.3 Fetal Monitoring Training

The fetal monitoring full day training commenced in September 2022 and compliance is monitored monthly. This training day is in addition to the session covered in mandatory training and contains a competency-based assessment which must be passed.

4. Safe Staffing

4.1 Maternity Staffing

The establishment of clinical midwives has been increased in light of the recent midwifery staffing paper to 111.41 whole time equivalents (wte).

Currently there is a Band 5 or 6 vacancy of 1.26 (wte). However, sickness absence and awaiting some of the staff offered posts to start does mean that the shift fill rate looks lower than might be expected for this level of vacancy. In addition, this does not reflect the new midwife posts to increase the establishment but that will go through vacancy panel and to recruitment in the next month. In December, positions were offered to two Band 5 midwives and two Band 7 Coordinators.

In December 5.6wte midwives were on maternity leave.

A Midwifery Apprentice was also interviewed and offered a position, to commence training March 2023.

4.2 Medical Staffing

Issue	Mitigation	Assurance
1 x consultant post vacancy	Locums used to cover any clinical activity where there is a gap.	Unsuccessful with recruitment. Approval given from Simon Enright to look at locum agencies. Two registrars' ready to apply for Certificate of Completion of training (CCT) in 2023, both can be interviewed in February and are keen to work in Barnsley.
2.4 x Registrar level 3 Entrustibility 0.4 gap due to less than full time vacancy	Locums used to cover the on-call gaps	Consultants will only remain on site during the on call if a Reg is on the Entrustibility matrix and no locum is secured and no other option is available. However, if this is the case activity for the following day would need to be cancelled. Where a locum is secured the Consultant will remain non-resident
2x vacancy at tier 1 (training gap) 1x Deanery 1x maternity leave	Vacancy now closed.	Recruited 2, both have accepted one starting in February and the other in March

5. Service User Feedback

Friends and family test (FFT) inpatient response rates for December 2022

In December 2022 there were 7 FFT responses for Maternity, all except one were positive comments. In response to the negative comment, in times of high acuity patients are asked to wait in the family room prior to leaving the ward. Patients are able to make refreshments and watch TV in a comfortable area whilst awaiting paperwork/transport. The ward lead is working with the ward team on communication issues to ensure women and families are fully aware of discharge dates and times. Actions from the FFT comments are contained within the Matrons report which is discussed monthly at Women's business and governance.

The MVP undertake a monthly walk around on the ward. This narrative, and any action plan is fed into the new monthly Maternity Patient Experience Action Plan – this will be launched at PEG and Women's Business and Governance in January 2023.

Ward	Very Good	Good	Neither Good or Bad	Poor	Very Poor	Total
Antenatal Clinic	0	0	0	0	0	0
Antenatal Day Unit	1	0	0	0	0	1
Community Midwifery	1	0	0	0	0	1
Antenatal Postnatal Ward	1	0	0	0	1	2
Barnsley Birthing Centre	3	0	0	0	0	3
Total	**6**	**0**	**0**	**0**	**1**	**7**

6. Staff feedback from frontline Safety Champions

Date	Feedback	Action taken
9th December 2022	I visited the birthing centre this morning. The unit was full, as was the ANPN ward, so the unit was busy. The coordinator was an experienced midwife and the unit appeared calm. I asked the coordinator to describe the bleep system which she did; she responded to a bleep test whilst I was on the unit. I observed the team working well together and responding to the needs of the unit by flexing the way they were working and by assessing and discussing risks and priorities. I spoke to a couple of continuity midwives who were supporting their women on the unit and I spoke to a student midwife who spoke positively about their experience and will consider working at Barnsley on completion of their training.	No action required
11th December 2022	I visited the unit of Friday afternoon, calling at both the Ante/post-natal and Neonatal Units. “Both areas were busy, with the ward particularly busy. The ward staff commented they had received help from the community team and a number of discharges where imminent which was allowing some movement from BBC. The staff while busy were very professional and seemed in good spirits.	Feedback provided to the Neonatal lead Nurse to share with staff.

	On Neonatal unit I spoke to the Units Clinical Educator who was working clinically, the unit had 11 babies and was staffed below the assessed level but feeling was that the staff available was sufficient based on the unit's immediate needs. We also briefly discussed transitional care and the challenges it gave at times."	

7. Action tracker from Maternal and Neonatal Safety Champions meeting

Minute ref	Meeting date	Item	Action	Owner	Due Date	Done Date	Progress report	RAG status
Action Log	10.11.22	BadgerNet Access for Maternity Colleagues	NG, LN and JC don't have BadgerNet access as yet due to licensing, this has been escalated to IT. NG will provide and update.	NG	12.1.23	9.1.23		GREEN

8. Trust Maternity Dashboard (Appendix F)

There continues to be over 30% of women booked onto a continuity of carer pathway. To date; November was the busiest month of 2022 with 266 women birthing. Periods of high activity and acuity were managed using the escalation policy with specialist midwives and community colleagues redeployed as needed.

9. Continuity of carer (CoC)

There have been no changes to the provision of continuity of carer this month. 36.8% of bookings were within the continuity of care teams in December 2022. The continuity teams continue to provide support to the unit when in escalation and the flexibility they provide enables the in-patient areas to remain open and flowing.

10. The Maternity Incentive Scheme- CNST (Appendix G)

The Board declaration form and accompanying presentation were presented on 5 January 2023 to Trust Board. The paper and presentation from the meeting are shared retrospectively with Quality and Governance today. Acknowledgement that the ATAIN action plan and the neonatal nursing qualified in speciality (QIS) action plan have been appropriately shared via the LMNS with the ICB was received on 16 Jan 2023. There is one outstanding query placed with NHS Resolution relating to a manual audit of data about the giving of antenatal steroids and magnesium sulphate in safety action 6. The action plan that relates to this audit is shared in the CNST paper.

The Trust Board gave approval for the Chief Executive and ICB Place Director to sign off the declaration form confirming full compliance with the 10 safety actions. The deadline for submission is 12 noon Thursday 2nd February.

11. Ockenden 7IEAs and 15IAs (Appendix H, I, J)

A further meeting took place with the LMNS to review the progress made in December 2022. Formal feedback is awaited and further actions will be completed following this. Initial feedback on the day was broadly positive and acknowledged the challenges of some of the outstanding actions. Monthly oversight of the seven IEAs continues at Women's Business and Governance and both reports are reviewed at the monthly Ockenden meetings chaired by the Head of Midwifery and Obstetric Consultant Lead.

Guidance is expected early this year that will combine the Ockenden and East Kent recommendations, to enable one action plan of maternity services improvement.

12. Preparation for CQC visit

A CQC inspection looking at safe and well led was announced in December but was subsequently postponed.

Work continues to ensure Maternity is prepared for a visit. Following a medication datix in December and a deeper dive into medicine datixes over the six months July to December 2022, a task and finish group is being implemented to review and align maternity medicine processes.

13. Guidelines

At the end of December thirty-three guidelines are out of date. Whilst this number now looks higher, despite improvements being made, the governance team have previously reported the number that are required approval once guidance has been merged.
This number will now be reflective of the TAD report.

In December four were approved at WB&G. The CBU3 overarching meeting was cancelled however, the quadrumvirate met to approved nine guidelines which are now available on the TAD.

A further four guidelines are scheduled for Women's B&G in January. However, these guidelines are not scheduled for quadrumvirate review until the 16th January, therefore subject to amendments it is anticipated they will be planned for CBU3 approval in February.

Appendix A - Barnsley Hospital NHS Foundation Trust Data Measures Table

CQC Maternity Ratings Jan 2016	Caring	Well-Led	Responsive	Overall
	Good	Good	Good	Good

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Number of perinatal deaths completed using Perinatal Mortality Review Tool	0	0	0	1	2	2	0	0	2	0	0	1
Number of cases referred to HSIB	0	0	0	1	2	0	0	0	0	0	0	0
Number of finalised reports received from HSIB	0	1	0	0	2	1	0	0	0	1	0	0
Number of finalised internal SI reports	0	0	0	1	0	0	0	1	0	0	0	0
Number of incidents graded as moderate harm or above	9	8	21	15	12	4	13	20	16	6	22	10
Number of Coroner's Regulation 28 Prevention of Future Death Reports in relation to maternity services	0	0	0	0	0	0	0	0	0	0	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly to the trust	0	0	0	0	0	0	0	0	0	0	0	0
Training compliance for all staff groups in maternity related to wider job essential training (%) (MAST)	87.4	87.4	87.4	-	-	86.47	88.60	86.99	87.2	86.50	86.24	84.40
Training compliance for all staff groups in maternity related to the core competency framework (%)(PROMPT) ***Reset to zero from January 2023***	0	52.9	60.9	70.2	79.2	77.46	94.9	94.9	94.9	94.9	98.9	98.9
Fetal monitoring training full day attendance (%)	-	-	-	-	-	-	-	-	5.1	16.5	22.2	28.5
1 to 1 care in labour %	98.26	99	99	100	100	99.6	99.6	100	99.5	100	100	100
BBC co-ordinator not supernumerary (Data from Birthrate plus®)	3	2	1	1	0	1	2	0	1	2	1	1
Midwifery Vacancy rate (WTE)	2.4	2.4	4.4	1.0	3.9	3.9	7.4	5.47	7.46	5.14	5.1	1.26
Medical Vacancy rate (WTE)	1.0	1.0	2.0	2.8	1.4	1.4	1.4	2.4	3.2	3.2	3.4	3.4
Women booked CoC %	46.6	48.6	33.8	37.1	32.1	30	28.9	32.4	32.3	36.5	34.3	Not available
Of those booked for CoC- Black, Asian and mixed ethnicity backgrounds %	40.0	85.7	0.0	42.9	53.0	50.0	0.0	13.33	60	25	53.3	Not available
Of those booked for CoC- <10th centile according to deprivation index %	46.0	45.5	20.3	24.4	17.0	23.0	14.0	19.6	35.5	18.5	Not available	
Of those booked for CoC, Intrapartum CoC received %	-	-	-	-	-	-	77.4	Not available				64.15%

Appendix B – PMRT

PMRT Notified cases

There were two cases notified within this period.

Case	Reason PMRT required	Final report due in the month of
84784	35+5 IUFD	June 2023
85174	31+5 Influenza A, sepsis, IUFD	June 2023

PMRT Reports completed

There was one PMRT case completed within this period.

PMRT Ongoing cases- BHNFT

Case	Reason PMRT required	Final report due in the month of
83101	24+1 IUFD known fetal abnormalities	February 2023 awaiting histology report
83173	22+5 placental abruption IUFD	February 2023 scheduled for the January meeting

PMRT Ongoing cases- Assigned to BHNFT

Case	Reason PMRT required	Lead Trust	Final report due in the month of
84721	Twin pregnancy; Twin 1 RIP 32/40 known T18	Sheffield- The Jessop Wing	May 2023
84318	NND 32/40 Booked at Doncaster, IUT to Barnsley	Leeds	May 2023
84350	NND 31+5/40	Sheffield- The Jessop Wing	April 2023
83728	Twin pregnancy; Twin 1 NND 34+4/40	Sheffield- The Jessop Wing	March 2023
83713	Late Miscarriage 22+2	Sheffield- The Jessop Wing	Overdue, all BHNFT information complete
83078	Twin pregnancy, Booked at LGI, Transferred to Barnsley for CS due to TTTS. Twin 1 NND	Sheffield Children's Hospital	Overdue, all BHNFT information complete
79670	33+1 Twins IUFD x1	Sheffield- The Jessop Wing	Overdue, all BHNFT information complete
80365	24+6 NND	Sheffield- The Jessop Wing	Overdue, all BHNFT information complete
81284	25+4 NND	Sheffield- The Jessop Wing	Overdue, all BHNFT information complete
81895	22+6 NND	Sheffield- The Jessop Wing	Overdue, all BHNFT information complete

Appendix C – HSIB/SI/HLR Reports

Cases referred to HSIB

There were no new cases reported to HSIB in December.

Ongoing HSIB cases

There are no ongoing HSIB cases.

Cases declared an SI/HLR

There were no cases declared a SI within this period.

Ongoing SI/HLR

Case ID	Summary	Investigation progress
INC- 90166	This was the mothers fourth pregnancy; a referral was made for a termination at query 4 weeks pregnant. On arrival the mother was more than 21 weeks so could not have a termination at BDGH. She was advised to self-refer to the British Pregnancy Advisory Service (BPAS). The mother did not proceed with the termination nor seek maternity care. The mother went on to birth twins at 31 weeks gestation after self-discharging and a community midwife follower the mother up at home. There were extensive safeguarding issues.	Amendments to be made following triumvirate review
INC-103079	Attended from out of area via ED with abdominal pain, found to be in the late stages of pregnancy and un-booked. The mother informed midwives she did not want or wish to see the baby. Therefore, maternity staff removed the child and placed on the neonatal unit and later then onto the paediatric ward. There was no escalation or liaison with external agency completed until 48 hours later. On review, the documentation of the incident was minimal and staff remain unclear of the legal standards for removal of children. The case was referred to social care and a legal order was obtained, baby has been subsequently placed in foster care. Immediate learning has been shared.	Amendments to be made following triumvirate review
INC-104819	First pregnancy, induction of labour for preeclampsia. Fetal heart rate concerns prompted a caesarean section. The mother required enhanced care following a return to theatre due to a post-partum haemorrhage and severe preeclampsia	Writing draft report
2022/22107	The mother birthed by emergency caesarean with an estimated blood loss of 400mls. In recovery the mother scored on their MOEWS and following review was transferred to enhanced care. Subsequently the mother was transferred to theatre for an Examination under Anaesthesia (EUA). Total blood loss was recorded as 3000mls. The mother then required ongoing care on ITU. The case was discussed at Patient Safety Panel and declared an SI due to an identification recurrent themes and the psychological impact the incident had on the mother.	Extension agreed at PSP 05/12/2022 until 23/02/2023
2022/22662	Patient attended gynaecology with a history of irregular bleeding for 7 months and a plan for follow up in 2-3 months was made. The patient did not receive an appointment despite chasing the appointment over a five-month period. Nine months later the patient was seen in clinic following an abnormal smear and subsequently diagnosed with stage 3 cervical cancer.	The timeline is being prepared

Finalised HSIB/SI/HLR reports

There were no finalised reports during this period.

Appendix D - Incidents graded moderate harm and above

Incidents graded moderate harm or above as per LMNS criteria	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Uterine rupture	0	0	0	0	0	0	0	0	0	0	0	0	0
Perineal tear (3rd/4th degree)	2	0	1	5	3	1	1	2	3	1	0	3	1
Unexpected hysterectomy	0	0	0	0	0	0	0	0	0	0	0	0	0
ICU Admission	0	0	0	1	0	0	0	0	1	1	0	0	1
Unexpected return to theatre	0	0	0	0	0	0	0	0	1*	0	0	0	0
Enhanced maternal care >48 hours	0	0	0	0	0	0	0	1	0	0	0	0	0
Postnatal readmission	1	2	0	6	5	2	2	4	3	3	3	6	0
Never events	0	0	0	0	0	0	0	0	0	0	0	0	0
Term admission to neonatal Unit (number)	7	4	6	8	6	7	8	5	10	11	3	12	7
Term admission to neonatal Unit (%) (national target <5%)	3.46	1.97	2.91	3.53	2.77	3.58	0.46	2.05	4.18	4.50	1.23	4.85	Not available
Fracture to baby that has resulted in further care	0	0	0	0	0	0	0	0	0	0	0	1	0
Perinatal loss	1	3	1	0	1	1	0	0	2	0	0	2	0
Maternal death	0	0	0	0	0	0	0	0	0	0	0	0	0
PPH	0	0	0	0	0	0	0	0	0	0	0	0	1

Ethnicity of patients who have suffered moderate harm and above

Ethnicity	Number of women												
	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	Dec 2022
White British	11	9	8	19	12	11	3	10	11	11	4	15	6
Any other white background	0	0	0	1	2	1	0	3	7	2	1	3	1

Any other mixed background	0	0	0	0	0	0	0	0	1	3	0	2	0
Black Caribbean or Black British Caribbean	1	0	0	0	1	0	0	0	0	0	1	0	0
Black African or Black British African	0	0	0	0	0	0	0	0	0	0	0	0	1
Not stated	0	0	0	0	0	0	0	0	1	0	0	1	0

Appendix E - Training compliance

Department	Business Security and Emergency Response	Conflict Resolution	Equality and Diversity	Fire Health and Safety	Infection Control Level 1	Infection Control Level 2	Information Governance and Data Security	Moving and Handling Back Care Awareness	Moving and Handling Practical Patient Handling Level 1	Moving and Handling Practical Patient Handling Level 2	Resuscitation Level 2 Adult Basic Life Support	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Overall Percentage
163 CBU 3 Management Team	93.33%	100.00 %	100.00 %	80.00 %	90.00 %	100.00 %	93.33%	100.00 %	33.33 %	75.00 %	85.71%	100.00%	75.00%	100.00%	89.39%
163 Maternity Establishment	97.13%	80.50%	98.85 %	90.23 %	91.67 %	88.27 %	74.14%	97.70%	52.78 %	50.00 %	80.00%	73.40%	88.89%	57.14%	83.85%
163 Obstetrics & Gynaecology Medical Services	86.11%	76.19%	100.00 %	77.78 %	81.82 %	60.00 %	80.56%	97.22%	80.00 %	N/A	72.00%	76.00%	81.82%	50.00%	81.85%

PROMPT

Training compliance CNST year 4 (PROMPT)												
Staff Group	December 21 (%)	January 22 (%)	February 22 (%)	March 22 (%)	April 22 (%)	May 22 (%)	June 22 (%)	July 22 (%)	Aug 22 (%)	Sept 22 (%) *	Oct 22 (%)	Nov 22 (%)
Midwives	-	0	28.27	36.66	51.72	64.82	85.81	96.45	96.45	96.45	95.56	99.26
Support workers	-	0	31.25	37.5	46.87	48.57	77.41	96.77	96.77	96.77	100	100
Obstetric consultants	-	0	30	40	50	60	80	90	90	90	100	100
All other obstetric doctors*	-	0	44.44	55.55	60	66.66	80.9	90.47	90.47	23.80	28.57	38.10
Obstetric anaesthetic consultants	-	0	39	43.47	52	61	74	91	91	91	91	95.45
All other obstetric anaesthetic doctors	-	0	8.3	16.66	25	33.33	66.66	91.6	91.6	91.6	100	100

*Percentage re calculated with the new doctors starting in September 2022, this does not affect the compliance for CNST year four.

Fetal Monitoring Training

Training compliance for fetal monitoring full day face to face training				
Staff Group	September 22 (%)	October 22 (%)	November 22 (%)	December 22 (%)
Midwives	3.57	14.2	21.42	28.6
Obstetric consultants	10	30	30	40
All other obstetric doctors	25	50	50	50
Overall percentage	5.1	16.5	22.2	28.5

Competency assessment undertaken and passed for fetal monitoring within the last 12 months (combined K2 and app bases test)	
Staff Group	**December**
Midwives inpatient	81.81%
Midwives outpatient	66.66%
Obstetric consultants	88.88%
All other obstetric doctors	100%

Appendix F - Maternity Dashboard

BHNFT Local Maternity Dashboard April 22 - March 23				Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Cumulative total
Clinical Activity	**Target**	**Amber**	**Red**													
Booked to Birth at BHNFT				251	255	243	302	282	312	227	242	256	254	299	256	3179
Number of BHNFT Bookings				230	227	215	265	248	269	201	195	206	183	251	225	2715
Booked elsewhere to Birth at BHNFT				36	37	40	46	41	56	36	40	48	69	48	31	528
Booked by BHNFT to Birth elsewhere				15	9	12	7	7	10	10	7	10	13	8	15	123
Booked onto Continuity of Carer pathway				123	123	118	105	107	104	72	72	84	80	109	91	1188
% of Continuity of Care	**25-35%**	**15-25%**	**<15 %**	46.0 %	46.6 %	48.6 %	33.8%	37.1%	32.1%	30.0%	32.0%	32.4%	32.3%	36.5%	34.3	N/A
% of BAME booked onto Continuity of carer pathway	**35%**			0.0 %	40.0 %	85.7 %	0.0%	42.9%	53.0%	50.0%	0.0%	13.3%	60.0%	25.0%	53.3	N/A
% of women booked onto Continuity of Carer pathway <10th centile according to the deprivation index	**35%**			43.0 %	46.0 %	45.5 %	20.3%	24.4%	17.0%	23.0%	14.0%	19.6%	35.5%	18.5%	Not available	N/A
Total Women birthed				221	218	215	244	216	236	243	260	249	263	261	266	2892
Sets of Twins				4	2	3	6	0	5	4	3	2	1	2	2	34
Total Births				225	220	218	250	216	241	247	263	251	264	263	268	2926
Live Births				224	217	217	250	215	240	247	263	251	264	263	268	2919
Live births at term				202	203	206	226	195	222	217	241	238	245	242	247	2684
Planned home births - Number				0	0	1	1	0	0	1	1	0	1	2	1	8
Number of times a second emergency theatre required.				1	0	0	1	0	0	0	0	3	0	0	2	7
In-utero Transfers Out				1	1	1	4	1	2	2	1	1	2	4	3	23
Unit Closed For Admission				0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Outcomes																
Normal Birth Rate	**>57%**			54.8 %	58.3 %	53.0 %	55.7%	52.5%	48.7%	48.6%	46.4%	49.8%	47.3%	48.3%	51.5%	N/A
Induction of labour Rate- Ratified	**≤32.8%**			36.6 %	29.8 %	30.2 %	32.0%	31.3%	28.8%	25.9%	25.1%	30.90 %	32.5%	35.7%	29.5%	N/A
Ventouse Rate	**≤5.2%**			4.5 %	5.0 %	4.7 %	4.1%	5.52%	6.80%	5.30%	8.0%	4.01%	4.1%	4.56%	4.9%	N/A

Forceps Rate	**≤7.3%**			8.6 %	5.0 %	7.0 %	6.1%	6.45%	5.50%	5.30%	4.9%	6.42%	5.7%	4.56%	5.2%	N/A
Total assisted vaginal births	**12.4%**			13.1 %	10.1 %	11.6 %	10.2%	11.98 %	12.20%	10.69 %	13.38%	10.44 %	9.84%	8.74%	9.7%	N/A
Emergency LSCS Rate				21.7 1%	18.3 4%	22.7 9%	22.13%	23.50 %	24.15%	27.20 %	28.46%	23.29 %	28.03 %	28.73 %	24.06%	N/A
Elective LSCS Rate				10.4 0%	13.3 0%	12.5 5%	12.29%	11.98 %	14.83%	13.20 %	11.92%	16.06 %	14.77 %	13.79 %	15.03%	N/A
3rd / 4th Degree tears total	**3.5%**		**>5%**	1.33 %	0.00 %	2.15 %	3.10%	2.85%	2.08%	1.37%	3.28%	1.20%	0.66%	0.76%	1.82%	N/A
3rd / 4th Degree tears - Normal Birth Total	**2.8%**			0.82 %	0.00 %	0.87 %	2.20%	2.63%	0.86%	0.84%	1.64%	0.00%	0.80%	1.57%	1.44%	N/A
				1	0	1	3	3	1	1	2	0	0	2	2	16
3rd / 4th Degree tears - Assisted Birth Total	**6.8%**			3.44 %	0.00 %	8.00 %	8.00%	3.84%	6.89%	3.84%	5.71%	10.74 %	0%	0%	3.84%	N/A
				1	0	2	2	1	2	1	2	3	0	0	1	15
PPH ≥1500mls	**<2.9%**		**>2.9 %**	0.45 %	3.21 %	1.86 %	2.04%	4.60%	2.11%	1.64%	2.69%	2.81%	3.40%	2.66%	2.63%	N/A
Neonatal Indicators																
Admission to neonatal unit ≥ 37 weeks				10	5	8	9	21	12	3	3	11	11	3	12	108
Admission to the NNU ≤ 26+6 weeks				0	1	0	0	1	1	2	0	1	0	0	0	6
Preterm birth rate <37 weeks	**≤8.3%**			10.2 %	6.8 %	5.0 %	9.6%	9.7%	7.5%	12.1%	7.6%	5.2%	7.6%	7.22%	7.5%	N/A
Preterm birth rate <34 weeks	**≤2.5%**			3.6 %	3.6 %	2.8 %	1.2%	3.2%	2.9%	3.2%	3.8%	2.4%	1.5%	3.04%	1.9%	N/A
Preterm birth rate <28 weeks	**≤0.5%**			0.4 %	0.9 %	0.0 %	0.0%	0.9%	0.4%	0.4%	0.0%	0.4%	0.4%	0.00%	0.0%	N/A
Low birthweight rate at term (2.2kg).	**≤3%**			0.5 %	1.0 %	1.0 %	0.4%	0.0%	1.4%	0.9%	0.4%	0.8%	1.1%	0.76%	0.0%	N/A
Right place of Birth	**95%**			100 %	99.5 4%	100 %	100%	99.50 %	99.50%	99.58 %	100%	99.60 %	100%	100%	100%	N/A
Mortality																
Neonatal deaths				0	1	0	0	0	1	1	0	0	0	0	1	4
Neonatal deaths excluding lethal abnormalities.				0	0	0	0	0	1	1	0	0	0	0	1** potential cause of death lethal abnormality as yet unconfirmed	3
Stillbirths				1	3	1	0	1	1	0	1	2	0	0	0	10
Stillbirths - Antenatal				1	2	1	0	1	0	0	2	2	0	0	0	9
Stillbirths - Intrapartum				0	1	0	0	0	1	0	0	0	0	0	0	2

Stillbirths - excluding those with lethal abnormalities				1	3	0	0	1	1	0	1	1	0	0	0	8
Stillbirths at Term				0	2	1	0	1	1	0	0	0	0	0	0	5
Stillbirths at Term with a low birth weight				0	0	0	0	0	0	0	0	0	0	0	0	0
HSIB reportable births				0	1	0	0	1	2	0	1	0	0	0	0	5
KPI's																
Women Initiating Breast Feeding at Birth	**≥75%**			61.8 %	62.8 %	61.4 %	61.5%	60.4%	67.0%	61.3%	60.1%	57.4%	64.2%	64.0%	56.4%	N/A
Breastfeeding rate at discharge				57.3 %	54.1 %	52.6 %	52.9%	53.9%	58.5%	51.0%	61.0%	50.2%	58.9%	56.3%	50.4%	N/A
Bookings <10 weeks	**≥90%**			80.4 %	72.6 %	75.8 %	74.3%	76.6%	72.9%	76.6%	76.0%	66.40 %	71.6%	73.9%	71.9%	N/A
Smoking rates at Booking	**≤6%**			19.4 %	16.7 %	16.4 %	19.9%	16.12 %	17.5%	19.9%	15.3%	13.6%	12.6%	15.8%	11.3%	N/A
Smoking at 36 weeks gestation	**≤6%**			7.2 %	5.5 %	10.1 %	5.3%	6.19%	18.8%	12.2%	11.2%	9.8%	10.2%	15.1%	Not available	N/A
Smoking Rates At Birth (SATOD)	**4-6%**	**6-8%**	**>8%**	19.0 %	14.2 %	11.2 %	13.1%	15.60 %	12.3%	14.0%	13.1%	13.1%	10.3%	14.9%	13.5%	N/A
Carbon Monoxide monitoring at time of booking	**≤6%**			15.6 %	13.4 %	12.6 %	15.2%	10.40 %	15.1%	18.5%	15.7%	9.4%	9.44%	15.41 %	Not available	N/A
Carbon Monoxide monitoring at 36 weeks	**≤6%**			9.5 %	10.5 %	13.1 %	11.4%	9.26%	14.9%	10.4%	9.8%	10.7%	10.47 %	9.4%	Not available	N/A
Workforce																
Midwife / Woman Ratio				1:26	1:26	1:26	1:26	1:26	1:26	1:26	1:26	1:26	1:26	1:28	Not available	N/A
1:1 care in labour				99%	98.62%	99%	99%	100%	100%	99.60 %	100%	99.5%	100%	100%	100%	N/A

Appendix G – CNST

Project aim: NHS Resolution is operating year 4 of the CNST MIS which incentivises 10 key maternity safety actions.	**Project Lead:** Deputy Head of Midwifery	**Trust Board declaration of completion:** trust check and challenge 30/11/22. Presentation to board 5/1/23.	Blue – action completed Red – significant risk Amber – in progress Green – on track

Safety Action 1	Safety Action 2	Safety Action 3	Safety Action 4	Safety Action 5	Safety Action 6	Safety Action 7	Safety Action 8	Safety Action 9	Safety Action 10

CNST Safety Actions	Summary of Progress
SA1 PMRT (Perinatal Mortality review tool)	Action complete
SA2 MSDS Dataset	Action complete
SA3 Transitional Care services in place and ATAIN recommendations (360 Assurance review)	Action complete- awaiting confirmation from LMNS that ATAIN action plan has been shared with the ICS
SA4 Clinical Workforce Planning	Action complete- awaiting confirmation that neonatal nursing qualified in speciality action plan has been shared with ICS (meeting 17th January, postponed meeting in December)
SA5 Midwifery Workforce planning	Action complete
SA6 Saving Babies Lives: (360 Assurance review)	Action complete- awaiting confirmation from NHSR regarding completion of declaration form. Manual audits completed to obtain evidence but not acknowledged on submission form as an option.
SA7 Working collaboratively with MVP	Action complete
SA8 Training (incorporating Ockenden Core Competency Framework)	Action complete
SA9 Safety Champions (360 Assurance review)	Revised safety action poster approved in December and displayed in the clinical areas
SA10 HSIB	Action complete
Key risks: None	**Escalations/support required with**: None

Appendix H - Ockenden 7 Immediate and Essential Actions

Project Aim: To enact the 7 Immediate Essential Actions arising from The Ockenden Report	**Project Lead**: Head of Midwifery and Obstetric Lead	Blue – completed action Red – significant risk Amber – in progress Green – on track

IEA 1	IEA 2	IEA 3	IEA 4	IEA 5	IEA 6	IEA 7

Immediate and Essential Actions	**Summary of Progress**
IEA1 Enhanced Safety	No change
IEA 2 Listening to Women and Families	No change, work on going
IEA3 Staff training and working together	Theatre practitioners have confirmed they will attend maternity training from January 2023, no confirmed staff for w/b 16.1.23.
IEA 4 Managing Complex Pregnancy	The audit for managing women with complex pregnancies has evidenced full assurance and is going through the approval process. The clinic lead is exploring the use of Tendable® for regular overview.
IEA 5 Risk Assessment through Pregnancy	Personalised care support plans remain a risk numbers 2108 and 2633. Work continues to produce a paper based personalised care plan as a digital solution not imminent.
IEA 6 Monitoring Fetal Wellbeing	No change regarding the recruitment for Fetal Wellbeing leads.
IEA 7 Informed Consent:	This continues to be monitored via FFT and complaints.

Key risks: None	**Escalations/support required with**: None

Appendix I - Ockenden 15 Immediate Actions

Project Aim: To enact the 15 Immediate Actions arising from The Ockenden Report	**Project Lead**: Head of Midwifery & Obstetric Lead	Blue – completed action Red – significant risk Amber – in progress Green – on track

IA 1	IA 2	IA 3	IA 4	IA 5	IA 6	IA 7	IA8	IA9	IA10	IA11	IA12	IA13	IA14	IA15

Immediate Actions	Summary of Progress
IA1 Workforce planning and sustainability	No change
IA 2 Safe Staffing	No change
IA3 Escalation and Accountability	No change
IA4 Clinical Governance Leadership	No change
IA5 Clinical Governance- Incident Investigation and complaints	No change
IA6 Learning from Maternal Deaths	No change
IA7 Multidisciplinary Training	No change
IA8 Complex Antenatal Care	No change
IA9 Preterm Birth	No change
IA10 Labour and Birth	No change
IA11 Obstetric Anaesthesia	No change
IA12 Postnatal Care	No change
IA13 Bereavement Care	Funding received to support 7 day a week access to the maternity bereavement team and additional staff to complete post-mortem consent training. Service provision currently being reviewed
IA14 Neonatal Care	AP phones available in clinical areas
IA15 Supporting Families	No change

Key risks: None	**Escalations/support required with**: None

Glossary

Term	Explanation
Ante-natal	Before birth the term pre-natal is also used
Better Births	A 2016 reports aimed at improving outcomes in maternity services
Primigravida	First pregnancy
EDD	Expected due date an estimation of when the baby will arrive. Only 2-5% of babies are actually born on their EDD
CTG	Cardiotocograph is a continuous monitoring of the fetal heart beat that produced as trace which can be categorised to asses fetal wellbeing.
Gestation	The period beginning from the first day of the last menstrual period until the birth of the baby. This can last up to 42 weeks.
Local Maternity and Neonatal System (LMNS)	https://sybics.co.uk/lmns
Post-Natal	The period until an infant is 28 days old
Fetal monitoring risk assessment	Risk assessment of fetal and maternal risk factors that decide on the level of fetal monitoring during labour available on the TAD
Fresh eyes	1 hourly process of another midwife not providing the 1:1 care to review the risks, CTG and plan of care. This has been shown to improve new-born outcomes.
Apgar Score	Soon after birth, observations are made of a baby's heart rate, breathing, colour, muscle tone and response to stimulation. These are performed at 1 minute and 5 minutes of age. There may be a third assessment at 10 minutes. The five observations are each given a score of 0, 1 or 2. The total of these scores is referred to as the Apgar score. If a baby requires resuscitation, the aim is to see the score rising, and the baby's condition improving.

4. Governance

4.1. Board Assurance Framework/Corporate Risk Register - Angela Wendzicha Interim Director of Corporate Affairs

For Assurance

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/4.1

SUBJECT:	**BOARD ASSURANCE FRAMEWORK/CORPORATE RISK REGISTER**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kim Traynor, Risk Management Co-ordinator				
SPONSORED BY:	Bob Kirton, Deputy Chief Executive Officer and Chief Delivery Officer				
PRESENTED BY:	Angela Wendzicha, Interim Director of Corporate Governance				

STRATEGIC CONTEXT

To provide the Board of Directors with the updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

EXECUTIVE SUMMARY

This paper provides an update on the latest position of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR); these are provided to the Board of Directors for information. All changes made to the documents since the last versions were presented are shown in italics and bold for ease of reference.

The BAF and CRR have been received by People Committee, the Quality and Governance Committee and the Finance and Performance Committee.

Board Assurance Framework

There remains to be 13 risks on the Board Assurance Framework; these have been mapped against the 2022/23 objectives.

A new strategic risk has been opened regarding the inability to improve the financial stability over the next two to five years; the Board is requested to consider the risk for escalation onto the Board Assurance Framework. The risk details are included in appendix 3.

Risk 1713 has been revised to reflect the short-term financial plan (risk of inability to deliver the in-year financial plan).

Corporate risk register

There are two new risks on the CRR; these are:

- Risk 2803 - risk to the delivery of effective haematology services due to a reduction in haematology consultants

  The risk score was increased from a 12 to a 16 following the reduced staffing position; there is now only one locum and one part-time substantive consultant. It was agreed that the risk would be included on the CRR at ET on 04 January 2023.

- Risk 2845 - Inability to improve the financial stability of the Trust over the next two to five years

  This is a new risk regarding the long-term financial stability of the Trust. It was agreed that the risk would be included on the CRR at ET on 18 January 2023.

There has been one risk de-escalated from the CRR; this is:

- Risk 2605 risk regarding the Trust's inability to anticipate evolving needs of the local population to reduce health inequalities

  This risk has been reviewed and downgraded to a 12 (high risk) stating that work is ongoing to build the healthy lives plan which is progressing well.

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RECOMMENDATION

The Board of Directors is asked to receive the BAF and CRR as assurance and approve risk 2845 for escalation onto the BAF.

1. Board Assurance Framework – current position

1.1 High-level summary of the one extreme risk on the BAF 22/23

Risk	Previous Score (Dec 22)	Current Score (Feb 23)	-/+	Update
2592 **(sits on BAF and CRR)** – Inability to deliver constitutional and other regulatory	15	15	→	No change since December BAF

1.2 High-level summary of the seven high (12+) risks on the BAF 22/23

Risk	Previous Score (Dec 22)	Current Score (Feb 23)	-/+	Update
2527 – Risk of failure to develop effective partnerships	12	12	→	No change since December BAF
2598 – Risk of inadequate support for staff wellbeing	12	12	→	No change since December BAF
1201 – Risk of non-recruitment to vacancies and retention of staff	12	12	→	No change since December BAF
2557 – Risk of lack of space and adequate facilities on site	12	12	→	No change since December BAF
2600 – Risk of failure to deliver timely and fit for purpose capital investments and equipment replacements	12	12	→	No change since December BAF
2122 – Risk of computer systems failing due to a cyber security incident	12	12	→	No change since December BAF
2605 – Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS) to reduce health inequalities to improve patient and population health outcomes	16	12	↓	Risk likelihood reduced following review

2. Corporate Risk Register – current position (appendix 2)

2.1 There have been two new risks escalated onto the CRR since the last presentation to the Board in December 2022:

- Risk 2803 - risk to the delivery of effective haematology services due to a reduction in haematology consultants

The risk score was increased from a 12 to a 16 following the reduced staffing position; there is now only one locum and one part-time substantive consultant. It was agreed that the risk would be included on the CRR at ET on 04 January 2023.

- Risk 2845 - Inability to improve the financial stability of the Trust over the next two to three years

This is a new risk regarding the long-term financial stability of the Trust. It was agreed that the risk would be included on the CRR at ET on 18 January 2023.

2.2 There has been one risk de-escalated from the CRR since the last presentation to the Committee; this is:

- Risk 2605 risk regarding the Trust's inability to anticipate evolving needs of the local population to reduce health inequalities

This risk has been reviewed and downgraded to a 12 (high risk) stating that work is ongoing to build the healthy lives plan which is progressing well.

2.3 Therefore, there are currently six risks on the Corporate Risk Register:

	Corporate Risk (Risk scoring 15+)	**Previous Score (Dec 22)**	**Current Score (Feb23)**	**-/+**	**Update**
1	2592 **(sits on BAF and CRR)** – Inability to deliver constitutional and other regulatory performance or waiting time targets	15	15	→	No change in score since December CRR
2	2243 – Risk regarding the aging fire alarm system	15	15	→	No change in score since December CRR
3	1199 – Risk regarding inability to control workforce costs	16	16	→	No change in score since December CRR
4	2813 – long-term gap in the maternity digital team impacting the data validity within the service	15	15	→	No change in score since December CRR
5	2803 – risk to the delivery of effective haematology services due to a reduction in haematology consultants	12	16	↑	New risk on the CRR
6	2845 – inability to improve the financial stability of the Trust over the next two to five years	-	16	-	New risk on the CRR

3. Recommendation

3.1 The Board is asked to receive the BAF and CRR.

Barnsley Hospital
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)
JANUARY 2023

Strategic Objectives 2022/23	Risk ID	High-Level Risk Detail	Sub-objective	Score	Risk Category (suggested)	Executive Owner	Status
Best for People	1201	Risk of non-recruitment to vacancies and retention of staff	We will make our Trust the best place to work	12	Workforce / Staff Engagement	Director ofWorkforce	Current
Best for People	2596	Risk of inadequate support for staff development	We will make our Trust the best place to work	***8***	Workforce / Staff Engagement	Director ofWorkforce	Current
Best for People	2598	Risk of inadequate support forstaff's health and wellbeing	We will make our Trust the best place to work	12	Workforce / Staff Engagement	Director ofWorkforce	Current
Best for Patients and The Public	2592	Risk of inability to deliver constitutional and other regulatory performance orwaiting time targets	We will provide the best possible care for our patients and service users	15	Clinical Safety /Patient Experience	Chief DeliveryOfficer	Current
Best for Performance	2595	Risk regarding the potentialdisruption of digital transformation	We will meet our performance targets and continuously strive to deliver sustainable services	9	Clinical Safety	Director of ICT	Current
Best for Performance	2122	Risk of computer systems failing due to a cyber securityincident	We will meet our performance targets and continuously strive to deliver sustainable services	12	Clinical Safety	Director of ICT	Current
Best for Performance	1713	Risk regarding inability to deliver the in-year financial plan	We will meet our performance targets and continuously strive to deliver sustainable services	4	Finance / Valuefor Money	Director ofFinance	Current
Best for Performance	1791	Risk regarding insufficient cash funds to meet the operational requirements ofthe Trust	We will meet our performance targets and continuously strive to deliver sustainable services	4	Finance / Valuefor Money	Director ofFinance	Current
Best for Performance	2557	Risk of lack of space and adequate facilities on-site tosupport the future configuration and safe delivery of services	We will meet our performance targets and continuously strive to deliver sustainable services	12	Clinical Safety /Patient Experience	Chief DeliveryOfficer	Current
Best for Performance	2600	Risk regarding inability to deliver timely and fit for purpose capital investments and equipment replacements	We will meet our performance targets and continuously strive to deliver sustainable services	12	Clinical Safety /Patient Experience	Director ofFinance	Current
Best for Partner	2527	Risk of failure to develop effective partnerships	We will work with partners within the South Yorkshire integrated Care System to deliver improved and integrated patient pathways	12	Partnerships	Chief DeliveryOfficer	Current
Best for Place	2605	Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes	We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	12	Clinical Safety /Patient Experience / Partnerships	Chief DeliveryOfficer	Current
Best for Place	1693	Risk of inability to maintain apositive reputation for the Trust	We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	6	Reputation	Director of Communicationsand Marketing	Current

Highlighted above are risks scoring 12+
Highlighted above are risks scoring 15+
Proposed for Closure
NEW Proposed

BAF Risk Profile

Risk Profile					
Likelihood > / Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
5 Catastrophic					
4 Major	**1791** (Insufficient cashfunds)	**2596** (Staff development)	**2527**(Effectivepartnerships) **2600** (Capital andequipment) **2598** (Staff wellbeing) **2122** (Cybersecurity) **2605** (Health inequalities)		
3 Moderate		**1693** (Trust reputation)	**2595** (Digital transformation)	**2557** (Lack of space) **1201** (Recruitment and retention)	**2592** (Performance targets)
2 Minor		**1713** (Financial stability)			
1 Negligible					

1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	High Risk
15 - 25	Extreme Risk

Risk Register Scoring

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the Risk Management Group recommends the removal of the risk from the corporate risk register.

Summary overview of Trust Risk Appetite Level 2021/22

	Relative Willingness to Accept Risk					
Category	**Avoid**	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
	1	2	3	3	4	5
Commercial						
Clinical safety						
Patient experience						
Clinical effectiveness						
Workforce/staff engagement						
Reputation						
Finance/value for money						
Regulatory/compliance						
Partnerships						
Innovation						

Assessment	Description of Potential Effect
LOWEST THRESHOLD	
Zero Risk Appetite Score – 1 **AVOID**	The Trust Board seeks to **avoid risks under any circumstances** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Low Risk Appetite Score – 2 **MINIMAL**	The Trust Board seeks to **avoid risks (expect in very exceptional circumstances)** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Moderate Risk Appetite Score – 3 **CAUTIOUS / OPEN**	The Trust Board is willing to **accept some risks in certain circumstances** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
High Risk Appetite Score – 4 **SEEK**	The Trust Board is willing to **accept risks** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
UPPER THRESHOLD	
Very High-Risk Appetite Score – 5 **MATURE**	The Trust Board **accepts risks** that are likely to result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.

Risk Appetite and Tolerance Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	CAUTIOUS
Partnerships	SEEK
Innovation	SEEK

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will make our Trust the best place to work	1201	People Committee	Director of Workforce	3x4	3x3	1769 - histopathologist shortages 2334 - nursing staff shortages 2572 - availability of consultant anaesthetist hours
Risk Description	**Consequence of Risk Occurring**		**Interdependencies**			
Risk regarding non-recruitment to vacancies and staff retention There is a risk that the Trust will be unable to recruit to vacancies or to retain permanent staff.	The materialisation of this risk could result in high vacancy rates, expensive agency spend, disengaged staff and insufficient skill-mix, potentially impacting on patient care and staff health and wellbeing.		Population health needs, service requirements (e.g. see histopathologist risk 1769), competing organisations, financial pressures, nurse staffing (see risk nursing staff shortages CRR risk 2334), dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided.			
Risk Appetite			**Risk Tolerance**			
Open (Workforce / Staff Engagement)			Treat			

Controls	Last Review Date	Next Review Date	Reviewed by	Control Gaps in
1. Support the 5-year Trust Strategy Plan and the Annual Business Plan - contribute to the integrated workforce, financial and activity plan, from which the data is used to predict capacity, supply issues, etc. Bi-annual Ward establishment reviews in place in February and September by the Deputy Director of Nursing's office	***Jan-23***	***Mar-23***	E Lavery	None identified
2.Workforce Planning Steering Group with representation from operational areas of the Trust (ADOs, apprenticeships, nursing, medical, etc.) has the CBU workforce planning packs to provide data for decision-making. The group monitors workforce KPIs including recruitment, supply, capacity and demand, etc.	***Jan-23***	***Mar-23***	E Lavery	None identified
3. Staff Redeployment, Staff Recruitment & Retention, Flexible Retirement, Staff Internal Transfer Scheme, Health & Wellbeing, Flexible Working, Rostering, Family Friendly Policies and Procedures	***Jan-23***	***Mar-23***	E Lavery	Talent Management & Succession planning - this is an area of improvement that is under review. SMART action planning underway. New Head of Leadership and Organisational Development has started in post in September 2022 and is responsible for the design and delivery of the Trust's talent management and succession planning framework and approach.
4. Alternative recruitment and selection search options in place to source candidates for hard to fill specialist posts.	***Jan-23***	***Mar-23***	E Lavery	None identified
5. Staff nurse recruitment action plan, including recruitment to Trainee Nurse Associate posts and careers pipeline for Nursing Associates to undertake Registered Nurse training through apprenticeship programmes. This action plan is overseen by the Nursing Workforce Group, which oversees nursing workforce numbers, student nurses, nursing vacancy gaps, international recruitment, and standardised newly qualified staff nurse recruitment process across the ICS.	***Jan-23***	***Mar-23***	E Lavery	Continuance of international recruitment reliant on successful pipeline.
6. People Strategy - a review of the strategy and development of a People Plan is underway to ensure alignment with the national NHS People Plan and to support delivery of the Trust 5 Year Strategy and Best for People strategic goals. This will focus on staff retention, wellbeing and development.	***Jan-23***	***Mar-23***	E Lavery	The Trust People Plan, to support delivery of the Trust 5 Year Strategy ***was approved at Trust Board in December 2022 subject to clear metrics being added on how the delivery of plan will be measured, before the document is launched.***

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Received By**		**Assurance Rating**	**Gaps in Assurance**
1. L1 - Nurse Staffing Report	Sep–22	Q&G	Full	None identified
3. L1- 360 Assurance Rostering Audit Report	Jan-22	Audit Committee	Partial	Rostering policy, rostering metrics and governance/reporting arrangements – all actions are now completed
4. L1 - Recruitment and Retention metrics Report	***Dec-22***	PEG	Full	None identified
5. L1 - Workforce Insights Report	***Nov–22***	PC	Full	None identified
6. L1 - CBU Workforce Plans	May-22	CBU Performance Review Meetings	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
1. Collaboration with other local NHS Trusts to understand the overall employment marketplace and take joint pre-emptive action where possible e.g.The Trust is part of the ICS approach to international recruitment	N/A	In progress	S Ned	On-going
2. Talent Management and Succession planning framework - see workforce development risk on BAF	N/A	In progress	T Spackman	Mar-23
3. Approval and launch of the Trust People Plan	N/A	In progress	E Lavery	***Jan-23***

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2022/23: Best for People	**Risk Ref:**	**Oversight Committee**		**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will make our Trust the best place to work	2596	People Committee		Director of Workforce	***4x2***	4x2	1201 - staff recruitment and retention 2598 - staff wellbeing
Risk Description	**Consequence of Risk Occurring**			**Interdependencies**			
Risk of inadequate support for staff development There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approachto succession planning, staff development and leadership development	The materialisation of this risk may jeopardise: 1. the development of robust clinical and non-clinical leadership to support service delivery and change; 2. staff being supported in their career development andto maintain competencies and training attendance; 3. staff retention; 4. and the Trust being a "well-led" organisation under the CQC domain 5. staff morale, health and well being			Dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress,spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff reduces the development opportunities for substantive staff.			
Risk Appetite				**Risk Tolerance**			
Open (Workforce/Staff Engagement)				Treat			
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**			
1. Appropriate staff development programmes in place e.g. Apprenticeship Schemes, Advanced Clinical Practitioner Training Programmes, Trainee Nurse Associate Training Programme. This willsupport development and upskilling.	***Jan-23***	***Mar-23***	E Lavery	None identified			
2. Nursing Workforce Development Programme. Current key actions on the plan include increased clinical placements and increased numbers of nurses and non-registered clinical support staff accessing apprenticeships and training through Universities and the Open University.	***Jan-23***	***Mar-23***	E Lavery	Local opportunities for non-registered staff continue to be developed through open university/university of Sheffield – degree apprenticeships			
3. People Strategy - a review of the strategy and development of a People Plan is underway to ensure alignment with the national NHS People Plan and to support delivery of the Trust 5 Year Strategy and Best for People strategic goals. This will focus on staff retention, wellbeing leadership and development. The aim will be to maximise effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effectivedelivery.	***Jan-23***	***Mar-23***	E Lavery	The Trust People Plan, to support delivery of the Trust 5 Year Strategy ***was approved at Trust Board in December 2022 subject to clear metrics being added on how the delivery of the plan will be measured before the document is launched.*** Talent Management & Succession planning and leadership development - this is an area of improvement that is under review. SMART action planning underway. New Head of Leadership and Organisational Development has started in post in September 2022 and is responsible for the design and delivery of the Trust's talent management, succession planning and leadership development framework and approach, and programme of activity Coherent Trust-wide learning from existing leadership development projects. Localised good performance and good practice may not be picked up across the Trust. Although it may not always be necessary or appropriatefor all Trust-wide learning in this area to be consistent, as opposed to tailored to meet specific leadership development requirements, it should be more coherent and delivered with more purpose. Unwarranted variation without justification may be a gap rather than variation itself.			
4. Training needs analysis model - annual programme focused on mandatory and statutory essentialtraining, which supports staff development and capability.	***Jan-23***	***Mar-23***	E Lavery	None identified			
5. Appraisal and PDPs schedule - there is a clear process to meet Trust appraisal and PDP targets. Guidance and supporting documentation to improve the quality of appraisal conversation has beenupdated and rolled out.	***Jan-23***	***Mar-23***	E Lavery	None identified			
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**			
1. L1 - Workforce Insights Report	***Nov-22***	P Committees	Full	None identified			
3. L2 - Staff Survey	Apr-22	Trust Board Assurance Committees	Full	None identified			
4. L1 - Pulse checks	Jul-22	PEG	Full	None identified			
4. HHE Training Doctors Quality Assurance Report	TBC	Trust Board Assurance Committees	TBC	TBC			

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
1. Delivery of the Nursing Workforce Development Programme.	N/A	In progress	B Hoskins	?
2. Talent Management & Succession planning ***& leadership development framework***	N/A	In progress	T Spackman	Mar-23
3. Approval and launch of the Trust People Plan	N/A	In progress	E Lavery	***Jan-23***

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will make our Trust the best place to work	2598	People Committee	Director of Workforce	4x3	4x2	1201 - staff recruitment and retention

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk of inadequate support for staff health and wellbeing There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approach to staff health and wellbeing.	The materialisation of this risk may jeopardise: staff morale, health and wellbeing patient safety and care staff retention and recruitment the Trust being a "well-led" organisation under the CQC domain	The pandemic has placed unprecedented demand on health and care staff across all settings and disciplines, leading to significant levels of stress and anxiety. There is a concern that there may not be enough staff to ensure staff well-being or patient safety; this is a national concern and challenge.

Risk Appetite	**Risk Tolerance**
Open (Workforce/Staff Engagement)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Occupational Health and EDI services have been re-organised to provide two distinct services(1. Occupational Health and 2. Wellbeing and Inclusion). This will enable a greater focus on the health and wellbeing offer to staff. Staff can access counselling and/or psychological support services, and can self-refer to occupational health where needed. The Trust has also introduced 'Wagestream' - a financial support product for staff to address any financial concerns. Quarterly People Pulse checks have commenced to better measure progress against key metrics from the staff survey, which includes the impact on staff wellness. New Culture metrics dashboard to measure staff experience and wellbeing and organisational culture has been approved at the People Committee in September 2022. A quarterly H&WB activity dashboard is also presented to the People & Engagement Group.	***Jan-23***	***Mar-23***	E Lavery	Lack of Workforce health and well-being organisational diagnostic to assess gaps in current provision and to benchmark service against areas of best practice. T&F Group has been set up in November 2022 to complete the NHSIE national H&WB diagnostic framework.
2. People Strategy - a review of the strategy and development of a People Plan is underway to ensure alignment with the national NHS People Plan and to support delivery of the Trust 5 Year Strategy and Best for People strategic goals. This will focus on staff retention, wellbeing and development. The aim will be to maximise the effectiveness of staff at every level of the Trust by coordinating a range of activities that will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effectivedelivery.	***Jan-23***	***Mar-23***	E Lavery	The Trust People Plan, to support delivery of the Trust 5-Year Strategy ***was approved at the Trust Board in December 2022 subject to clear metrics being added on how the delivery of the plan will be measured before the document is launched***
3.The Trust is also working with the ICS to access wider sources of health and wellbeing support. the successful appointment of a Band 5 Specialist Staff Counsellor, EDI Lead for Health & Wellbeing Band 7 1.0wte, Healthy Lifestyles Checks Officer Band 4 1.0wte, and VIVUP on-site Staff Counsellor 0.2wte which has been funded through the ICS. The SYB ICS Mental Health & Wellbeing hub of online resources, materialsand training courses has been made available to all staff. The Trust will also be appointing an Occupational Psychologist post shared with Rotherham Trust for a period of 2 years funded by NHS national charities funds	***Jan-23***	***Mar-23***	E Lavery	None identified
4. The Trust has approved the adoption of the Standards Framework for Counsellors & CounsellingServices for BHNFT and partners to strengthen the wellbeing support offered. An agreement has also been reached to extend the Schwartz Rounds contract for an additional 3 years. The Schwartz Rounds steering group has been re-instated and the programme of Schwartz Rounds sessions agreed.	***Jan-23***	***Mar-23***	E Lavery	None identified
5. Appointment of a Health and Wellbeing Guardian as approved by the Board to ensure dedicatedoversight and assurance that the staff health and wellbeing agenda has a Board level champion. Anon-executive director has commenced in the role on 01/10/21.	***Jan-23***	***Mar-23***	E Lavery	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
1. L1 - Workforce Insights Report	***Nov***-22	P Committee	Full	None identified
2. L1 - CBU Workforce Plans	May-22	CBU Performance Review Meetings	Full	None identified
3. L2 - Staff Survey	Apr-22	Trust Board Assurance Committees	Full	None identified
4. L1 - Pulse checks	***Jul***-22	PEG	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
1. Review NHS Workforce Health and Wellbeing Framework diagnostic tool and consider use of assessment to ascertain areas of focus. Also receive 360 Assurance internal audit report findings and act on recommendations into the Trust's health and wellbeing offer including the use of metrics to inform future action plan.	Sep-21	In progress	E Lavery	***Feb-23***
2. Development of performance indicators against staff engagement and well-being initiatives to better measure impact on staff wellness and organisational culture.	Sep-21	In progress	S Ned	***Feb-23***
3. Approval and launch of the Trust People Plan	N/A		E Lavery	***Jan-23***

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Patients and The Public	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will provide the best possible care for our patients and service users	2592	Finance and Performance Committee	Chief Delivery Officer	5x3	5x2	1201 - staff recruitment and retention2557 - lack of space and facilities 2600 - failure to deliver capital investment and equipment replacement

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk of inability to deliver constitutional and other regulatory performance or waiting time targets There is a risk that the Trust will fail to deliver constitutional and other regulatory performance or waiting time standards / targets considering capacity to cope with increased service demand anticipated over the coming year	The materialisation of this risk will result in a breach in standards and potentially have an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm due to delays in access to care.	Uncertainties surrounding the current pandemic and its impact on service capacity and demand; system partners and their ability to meet the needs of their service users; safe staffing levels and challenges with recruitment in various services across the Trust; well and supported staff to be able to deliver the services; space and equipment to meet the needs of the services. Revised operational priorities for 2022/23 are aligned to but not reflective of constitutional target delivery

Risk Appetite	**Risk Tolerance**
Cautious (Regulatory)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	***Jan-23***	***Mar-23***	B Kirton/ L Burnett	None identified
2. Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET	***Jan-23***	***Mar-23***	B Kirton/ L Burnett	Unknown future demand for services may lead to surge in referrals above available capacity. Staff absence and vacancies are the biggest risk.
3. Monitoring of activity of performance of NHSE/I (regulator) via systems meetings.	***Jan-23***	***Mar-23***	B Kirton/ L Burnett	None identified
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	***Jan-23***	***Mar-23***	B Kirton/ L Burnett	Impact on Health inequalities
5. Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	***Jan-23***	***Mar-23***	B Kirton/ L Burnett	Moving to 12 hours from attendance at ED rather than decision to admit

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
1. L2: - IPR report	Mar-22	F&P Committee	Full	None identified
2. L2: - Progress reports - annual business plan	Apr-22	F&P Committee	Partial	Performance is measured at a system level
3. L3: - NHSI/E reports	Mar-22	Trust Board	Full	None identified
4. L3: - Benchmarking reports through ICS	Apr-22	Trust Board	Full	None identified
5. L1: - Reports against trajectories	Mar-22	F&P Committee	Partial	A number of actions to enable recovery require involvement of place & system and are not under the direct control of the Trust
6. L2: - Quality Metric Reports	Apr-22	F&P Committee	Full	None identified
7: L2: - Report to Trust Board - Activity Recovery Plans 2021/22 and further updates to assurance committees	Mar-22	Trust Board	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1 and 4: Clinical exec leads to ensure appropriate process for monitoring risk of harm to patients on waiting lists (see risk 2605 for further detail). Started June 21.	Feb-21	complete	Dr S Enright	complete
Control 2 and Assurance 5: Adapt performance reporting so they provide the right assurances on what the Trust has committed to deliver. Started January 21.	May-21	Complete	L Burnett	complete
Control 2: Continue to increase endoscopy activity to enable recovery. Capacity gap identified in business planning & additional activity requirements discussed with finance director	Apr-22	Complete	S Garside	complete

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2595	Finance and Performance Committee	Director of ICT	4x2	4x1	1693 - adverse reputational damage to the Trust1 713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients 2098 - Transformation digital programme

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
<u>Risk regarding the potential disruption of digital transformation</u>. The trust is committed to large digital transformation projects (Including Electronic Prescribing, Clinical Messaging and Electronic Health care Records replacing current paper notes), unless this programme of work is delivered safety and effectively there is a significant risk to clinical operational delivery.	The materialisation of this risk could result in: - Poor understanding and misalignment of the changes to clinical processesresulting in harm to patients. - Poor Communication and engagement resulting in poor adoption of the changeand escalating costs. -Potential implications to the overall management and board due to not understanding the full-term risks and impacts of the digital transformations. - Lack of Governance resulting in disruption in supporting clinical, administration and operational services and unsafe processes.	BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery.

Risk Appetite	**Risk Tolerance**
Seek	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Effective governance via the Careflow Steering group involving strong executive leadership. Project Senior Responsible Owner (SRO) and Clinical Lead.	***Jan-23***	***Mar-23***	Director of ICT	None identified
2. Effective training, project delivery, communications, engagement with all staff in line with an approved project initiation document.	***Jan-23***	***Mar-23***	Director of ICT	Potential impacts of external factors such as COVID-19 on workforce and therefore delivery (outside of the Trust's control)
3. External review of processes and implementations via the Trust System Support Model (TSSM)	***Jan-23***	***Mar-23***	Director of ICT	None identified
4. Digital Transformation Strategy	***Jan-23***	***Mar-23***	Director of ICT	It is not possible for the Strategy to manage unforeseen disruption and clinical risks.
5. Business Cases for E-prescribing, Electronic Health Care Records and Careflow (Medway) Lorenzo replacement	***Jan-23***	***Mar-23***	Director of ICT	None identified
6. Clinical Safety Officer Role in Place and Clear up to date Clinical safety assessments and hazard logs.	***Jan-23***	***Mar-23***	Clinical Reference Group/Director ICT	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
1. L1 Careflow Steering Group Chairs Log	***Jan-23***	F&P	Full	None identified
2. L3 Significant Assurance 360Assurance Report Transformation (New EPR) Rollout	Sep-21	Board	Full	None identified
3. L1 F&P ICT Strategic Update - Digital Transformations in Delivery	***Jan-23***	F&P	Full	None identified
4 .Monthly F&P ICT Strategic Update – Digital Transformations in Delivery	***Jan-23***	F&P	***Full***	***None identified***

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Careful monitoring of the programme of digital transformation via all trust board committees.	On-going	N/A	Director of IT	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2122	Finance and Performance Committee	Director of ICT	4x3	4x1	2416 – cyber-security during the pandemic 1693 - adverse reputational damage to the Trust 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients 2098 - Transformation digital programme
Risk Description	**Consequence of Risk Occurring**		**Interdependencies**			
Risk regarding Cybersecurity and IT systems resilience There is a risk that computer systems will fail due to a cyber-security incident. This risk is increased if there is a lack of support for maintaining clinically critical systems. This risk has increased due to the recent issues with Adastra 111 Response Cybersecurity Incident, All trusts have been asked to increase our robust surveillance of all our cybersecurity attack points.	The materialisation of this risk could impact on operational and clinical services in the Trust. This could compromise the Trust's infrastructure and would result in poor patient experience and care. This may also have financial, reputational and legislative implications. There could also be a data loss or theft affecting patients, staff or finances.		BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery.			
Risk Appetite			**Risk Tolerance**			
Minimal (Clinical Safety)			Treat			

Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control
1. Currently all clinical and business critical systems have external support. Minor non-critical systems are supported internally.	***Jan-23***	***Mar-23***	Director of ICT	IT systems and business as usual support continually gets more complex and there are limited resources to ensure mitigation of all risks.
2. A regular review of assessment is carried out to ensure that business critical computer solutions are supported externally and a risk assessment is completed on minor unsupported solutions. A paper was received at ET to approve this approach.	***Jan-23***	***Mar-23***	Director of ICT	None identified
3. Intrusion Detection, Firewalls, URL Filtering, Vulnerability Scanning, Penetration Testing, Anti-Virus, Anti-Malware and Patching strategies in place.	***Jan-23***	***Mar-23***	Director of ICT	There is no protections against a zero-day virus. A brand-new virus that cannot be detected by the various scanning techniques. Careful and consistent monitoring of systems need to be in place through start of the day checks
4. CARECert – Cybersecurity Alerts – for example recent LOG4J alert and remedial actions report to F+P	***Jan-23***	***Mar-23***	Director of ICT	Full assurance from all suppliers has been sought. Some suppliers have provided workarounds but not supplied full patches.
5. Annual Cybersecurity assessment completed by Certified 3rd party to ensure all up to date measures are in place	***Jan-23***	***Mar-23***	Director of ICT	Not all recommendations in the report can be completed; it is a balance of funding/practicality/risk to ensure the most effective cybersecurity controls are implemented.

Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	ReceivedBy	Assurance Rating	Gaps in Assurance
1. L3 Covid-19 risk assessment of all cybersecurity and IT risks. Significant Assurance provided from 360 Assurance on out Data Protection Toolkit compliance position – Board approved position.	May-21	ET and F&P	Full	No dedicated cybersecurity personnel as recommended by NHS Digital 360 assurance report.
2. Annual Board cybersecurity report including Penetration Testing Results	Apr-22	ET, F&P and Board	Full	None identified
3. Data Protection and Security Toolkit	May-22	ET, F&P and Board	Partial	Only covers specific areas of cybersecurity.
4. National Cybersecurity active monitoring and reporting frameworks	***Jan-23***	ICT Directorate	Partial	The highly technical reports are not shared with the Board and Sub-committees.

Corrective Actions Required (include start date)	Action Due Date	Action Status	Action Owner	Forecast Completion Date
Bolster online defences and order new penetration test.	01/04/2023	***In Progress***	***ICT Director***	***31/04/2023***
Control 5. Complete full firewall installation and expert assessment from CAE Network Solutions	31/07/2022	***Complete.***	***ICT Director***	***Complete***
Control 1 and 4. Strategic update report to the finance and performance committee monthly to manage resources against priorities	Ongoing			
Control 3. Careful and consistent monitoring of systems need to be in place through start of the day checks and CareCert National Cybersecurity Monitoring	Ongoing			
Control 5. Ensure fully risk assessed gaps in cybersecurity action plan delivery.	Ongoing			

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current RiskScore**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	1713	Finance and Performance Committee	Director of Finance	***2x2***	2x1	1943 - failing to deliver adequate CIP scheme1791 - inefficient cash funds
Risk Description	**Consequence of Risk Occurring**		**Interdependencies**			
Risk regarding inability to deliver the in-year financial plan ***There is a risk of failing to deliver the in-year financial plan, including any required efficiency and clinical activity, in accordance with national and system arrangements. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.***	The materialisation of this risk would adversely impact on the financial stability of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage.		The activity and demand within the system. The SY ICS financial position.The current financial framework in operation. Covid-19 and recovery pressures.			
Risk Appetite			**Risk Tolerance**			
Open (Finance / Value for Money)			Treat			

Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control
1. Board owned financial plans	***Jan-23***	***Mar-23***	R Paskell	None identified, Board approved final 2022/23 plan in June
2. Requirements identified through business planning and budget setting processes and prioritised based on current information	***Jan-23***	***Mar-23***	R Paskell	Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control
3. Additional requirements must follow business case process	***Jan-23***	***Mar-23***	R Paskell	None identified - well established business case process
4. Financial performance is reviewed and monitored at monthly CBU performance and Finance &Performance Committee meetings	***Jan-23***	***Mar-23***	R Paskell	None identified
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans	***Jan-23***	***Mar-23***	R Paskell	Group is now meeting, however Covid-19 and recovery pressures continue to impact upon management time and ability to focus on cost management
6. Barnsley place efficiency group established to identify, monitor and support delivery of system opportunities	***Jan-23***	***Mar-23***	R Paskell	Lack of Trust control over financial performance of external partners
7. Identification of additional efficiency / spend reduction.	***Jan-23***	***Mar-23***	R Paskell	Covid-19 and recovery pressures impacting upon management time and ability to focus on cost management
8. Continued work on opportunities arising from PLICS / Benchmarking and RightCare	***Jan-23***	***Mar-23***	R Paskell	Covid-19 and recovery pressures impacting upon management time and ability to focus on cost management
9. Tight management of costs, with delegated authority limits, including review of agency usage	***Jan-23***	***Mar-23***	R Paskell	Covid-19 and recovery pressures impacting upon management time and ability to focus on cost management
10. Continued discussions with SY ICB.	***Jan-23***	***Mar-23***	R Paskell	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P	Oct-22	F&P	Partial	Pressures arising from Covid-19, recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Gaps in control in relation to controls 5, 7, 8 & 9 – Efficiency and productivity paper, including reporting and governance arrangements to F&P	N/A	Completed	C Thickett	N/A
Gaps in control in relation to controls 2, 6 & 10, which are outside the Trust's control	N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	1791	Finance and Performance Committee	Director of Finance	4x1	4x1	1943 - failing to deliver adequate CIP scheme 1713 - maintaining financial stability

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk regarding insufficient cash funds to meet the operational requirements of the Trust There is a risk of insufficient cash funds to meet the operational requirement of theTrust, with services having to cease as a result	The materialisation of this risk would impact on the ability to carry out servicesat the Trust. To enable services to continue the Trust would have to seek emergency cash from NHSE/I	The activity and demand within the system. The Barnsley SY ICS financial position.The current financial framework in operation. Covid-19 and recovery pressures.

Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Standing operating procedures in places regarding cash management, including daily micro-management of cash and long-term cash forecasting	***Jan-23***	***Mar-23***	R Paskell	None identified - good processes in place which have been reviewed by both internal and external audit
2. Apply for distressed funding (only when required)	***Jan-23***	***Mar-23***	R Paskell	Only when required - Support required from NHSE/I; timing of approvals process and cash receipt outside of the Trusts control
3. Ensure debtors pay the Trust ASAP	***Jan-23***	***Mar-23***	R Paskell	Lack of Trust control over financial performance of external partners and debtor's ability to pay
4. Ensure creditors are managed and the Trust is not placed on "STOP"	***Jan-23***	***Mar-23***	R Paskell	None identified - ensure all invoices are received and receipted in a timely manner, with any disputes escalated as appropriate

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2 - Integrated performance report/finance report	Oct-22	F&P Committee	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
The only gaps in control relate to controls 2 & 3, both of which are outside the Trust control	N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current RiskScore**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2557	Finance and Performance Committee	Chief Delivery Officer	4 x 3	3 x 2	2527 - ineffective partnership working 2404 - compromised care for non Covid-19 patients 1713 - maintaining financial stability against the financial plan 2598 - digital transformation programme

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk of lack of space and adequate facilities on site to support the future configuration andsafe delivery of services There is a risk that there is a lack of space on site to support the future configuration of services. The level of estates work and service developments that require space within the hospital has led to the displacement of current staff and services alongside significant disruption and congestion on the site.	The materialisation of this risk will impact on the Trust's ability to deliver business as usual services, leading to potential delays, and impacts on clinical safety and patient experience. The materialisation of this risk may also negatively impact working conditions, and lead to a reduction in staff morale.	There are interdependencies with partnership working and the wider service demand for the region, as well as the ongoing Covid 19 pandemic and recovery plans. Thisrisk is also interdependent on capital finance, digital transformation, and may impact on the trusts ability to deliver the services within the trust 5-year strategy

Risk Appetite	**Risk Tolerance**
Cautious (Patient Experience)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes	***Jan-23***	***Mar-23***	B Kirton	None identified
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	***Jan-23***	***Mar-23***	B Kirton	None identified
3. Home working is being promoted at all levels via departmental managers to enable shared desksand the release of space	***Jan-23***	***Mar-23***	B Kirton	None identified
4. Space Utilisation Group	***Jan-23***	***Mar-23***	B Kirton	None identified
5. Contracts and SLAs between the Trust and BFS	***Jan-23***	***Mar-23***	B Kirton	None identified
6. EDMS Project (reduce paper in the Trust and in turn, release space)	***Jan-23***	***Mar-23***	T Davidson	Awaiting completion of project & space release
7. Trust 5-year strategy	***Jan-23***	***JMar-23***	B Kirton	None identified
8. Urgent care improvement plan, to increase same day emergency care, to provide navigator role and separate GP stream. All will reduce need for inpatient beds	***Jan-23***	***JMar-23***	B Kirton	Subject to ongoing review and update
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	***Jan-23***	***Mar-23***	B Kirton	Dependent on adjacent projects and interdependencies
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	***Jan-23***	***Mar-23***	B Kirton	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
L1 - Trust Ops regular agenda item	***Jan-23***	CBU Performance Meetings	Partial	
L1 - Regular agenda item on ET	May 22	ET	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated
L2 - BFS performance chairs log	***Jan-23***	F&P Committee	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated
L3 - Item on agendas at Barnsley Place meetings, UECB, planned care & ICP	***Jan-23***	ICP	Full	None identified at PLACE

Corrective Actions Required (include start date)	**Action Due Date**	***Action Status***	**Action Owner**	**Forecast Completion Date**
Control 5: Director of Finance and Managing Director of BFS to review SLAs and contracts to ensure up to date and reflective of agreed arrangements	Jun-21	Complete	L Christopher	
Control 1. Director of Operations to provide Joint Partnership Forum with update of service change & estate plans to ensure staff communications	Jun-21	Complete	Lorraine Burnett	
Control 2. Final services to move offsite and release space for start of critical care build	May-21	Complete	R McCubbin/ E Lavery	
Control 4. Space Utilisation Group to be recommenced	Jun-21	Complete	M Hall	
Control 10. Formalise exception updates on space from weekly trust Ops to monthly CBU performance report	May-21	Complete	L Burnett	
Control 2: Development of the community diagnostic centre	Apr-22	Move to phase 2	L Burnett/ R McCubbin	***Jun-23***
Control 8. Winter plan developed and all available inpatient bed capacity open	Sept 22	Complete	L Burnett	
Control 9. Theatre efficiency & productivity group established and planned care recovery action plans to ensure increase in day case rate & utilisation metrics.	Nov 22	complete	L Burnett	

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current RiskScore**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2600	Finance and Performance Committee	Director of Finance	4x3	2x2	1713 - maintaining financial stability against the financial plan 1791 - inefficient cash funds to meet operational requirements

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk regarding inability to deliver timely and fit for purpose capital investments and equipment replacements There is a risk that the Trust may not have sufficient funding to invest in allof the required capital developments for estates improvements, IM&T, the replacement of equipment and other business requirements over the longer term to meet service needs, safety and regulatory standards	The materialisation of this risk could result in negative impacts on timely service delivery, patient safety and experience, achievement ofperformance targets and regulatory standards.	The SY ICS financial position and capital allocation available. Delivery of the Trust financial plan. Availability of additional national funding. The current financial framework in operation.Covid-19 and recovery pressures. The activity and demand within the system.

Risk Appetite	**Risk Tolerance**
Seek (Innovation)	Treat

Controls	**Last ReviewDate**	**Next ReviewDate**	**Reviewed by**	**Gaps in Control**
1. Multi-year capital plan and annual programme overseen by Capital Monitoring Group, including specific riorisation for estates, IM&T and M&S programmes	***Jan-23***	***Mar-23***	R Paskell	None identified.
2. Capital requirements identified through business planning processes and prioritised based on current information.	***Jan-23***	***Mar-23***	R Paskell	Long term capital funding available remains unclear. Capital allocations now received and controlled via the ICS with some national funding available through a bidding process.
3. Capital Monitoring Group in place which reviews and manages all capital spend.	***Jan-23***	***Mar-23***	R Paskell	Long term capital funding available remains unclear. Capital allocations now received and controlled via the ICS with some national funding available through a bidding process.
4. M&S group in place, with Executive Director representation, to review and manage M&S spend considering the views of MedicalEngineering and CBUs.	***Jan-23***	***Mar-23***	R Paskell	Long term capital funding available remains unclear. Capital allocations now received and controlled via the ICS with some national funding available through a bidding process.
5. BFS maintain all equipment to an appropriate standard, with planned preventative maintenance (PPM) undertaken.	***Jan-23***	***Mar-23***	R Paskell	None identified.
6. Equipment register in place which is used to identify replacement needs based on age of equipment and risks identified with CBUs.	***Jan-23***	***Mar-23***	R Paskell	None identified.
7. Estate backlog register updated annually to assist prioritistaion of annual investment.	***Jan-23***	***Mar-23***	R Paskell	None identified.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
1: L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICSperformance papers to PF&P, CMG chairs log to F&P	Oct-22	F&P Committee	Partial	Pressures arising from Covid-19, recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations. Clarification on the future national capital available and the implications of this for Barnsley.
2: L1 - Risk escalation via the Risk Management Group regarding equipment risks, and assurances and mitigation	Dec-22	Risk Management Group	Partial	Reliant upon CBUs identifying issues and escalating via the appropriate routes.

Corrective Actions Required (include start date)	**Action DueDate**	**ActionStatus**	**Action Owner**	**Forecast Completion Date**
Overall action to support gaps across controls and assurances: Review of estates requirements following the initial strategy development sessions with CBUs. Prioritisation is to be undertaken in the form of a detailed delivery plan underpinning the high-level Estates strategy. The project will be supported by Barnsley Estates	Jun-22	In Progress	CMG	***Jan-23***

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Partners	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will work with partners within the South Yorkshire integrated Care System to deliver improved and integrated patient pathways	2527	Finance and Performance Committee	Chief Deliveryofficer	4x3	4x2	1693 - adverse reputational damage to the Trust

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk regarding ineffective partnership working and failure to deliver integratedcare There is a risk that the Trust will have ineffective partnerships due to the failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives in which we work to act together to deliver integrated care, maintain financial equilibrium and share risk responsibly. This may be due to competing priorities, lack of resource, overdependency on a partner, competition, lack of engagement with partners or the public. This includes our partnerships in Barnsley Place, the ICS and our acute partnerships.	The materialisation of this risk could lead to a lack of joined up planning, loss of public confidence, reputational damage and the inability to develop new ideas/ways of working. The overall impact could include a lack of joined-up patient care and failure to tackle health inequalities bothleading to poorer outcomes for the local population.	Wider system pressures, partner organisations' capacity and ability to collaborate, Trust capacity and ability to collaborate, etc. This risk will also be impacted by national constitutional changes due by March 2022.

Risk Appetite	**Risk Tolerance**
Seek (Partnerships)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Trust vision, aims and objectives	***Jan-23***	***Mar-23***	B Kirton	None identified
2. Communications and Engagement strategy (Trust approach for collaboration withpartners, public, etc.)	***Jan-23***	***Mar-23***	B Kirton	none identified
3. Membership of partnership forums in Barnsley Place and SYB ICS.	***Jan-23***	***Mar-23***	B Kirton	Ongoing understanding of the implications of the agreed legislative changes as ICB's took legal form from July 2022. There is an emerging governance structure that links through to ICB place teams that the Trust needs to input into and understand in terms of engagement and accountability
4. Regular meetings with partners, Chair meetings and exec to exec working.	***Jan-23***	***Mar-23***	B Kirton	None identified
5. Membership of networks and service level agreements	***Jan-23***	***Mar-23***	B Kirton	Some service level agreements remain unsigned, which will be addressed through the CBU's and finance

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
1. L1 - regular ET agenda item regarding Barnsley and ICS meetings	Sep-21	ET	Full	None identified
2. L2 - Monthly Board updates regarding Barnsley Integrated Care Partnership andSouth Yorkshire and Bassetlaw ICS	Oct-21	Board	Partial	There is an Alliance contract that is not being effectively monitored. Awaiting the ICS governance review and implications of the recent white paper on "integrating care".

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Review of governance relating to services providing intermediate care via Rightcare Barnsley (Assurance 2). We are dependent on the CCG as they are leading on the review of the service. The Trust is awaiting formal feedback from CCG following procurement processes.	Feb-21	complete	L Burnett	Mar-22
Review of unsigned service level agreements and take any necessary actions to address the gap (Control 5). There are no material concerns at the present time	Apr-21	Overdue	C Thickett	Aug-22
Review of the legislative changes and emerging ICB governance (Control 3 and Assurance 2). The ICB place team have the final proposed governance structure and TOR for all the meetings to take to Board in February.	In progress	In progress	B Kirton	Febv-23

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	2605	Quality and Governance Committee	Chief Delivery Officer	***4x3***	3x3	2527 - ineffective partnership working 2592 - failure to deliver performance/targets
Risk Description	**Consequence of Risk Occurring**		**Interdependencies**			
Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes There is a risk that we will not take appropriate action to address health inequalities in line with local public health strategy, which has six priorities: tobacco control, physical activity, oralhealth, food, alcohol and emotional resilience. There is also a risk that we may fail to work effectively with our PLACE and ICS partners to meaningfully reduce health inequalities, and improve patient and population health outcomes.	The worsening of this risk could result in further inequity of access, experience and outcomes for service users and the local population. Demand continues to grow in an unpredictable way, with a knock-on effect on unplanned care delivery, which is already a challenge.		Wider system pressures, partner organisations' capacity and ability to collaborate, and partner's recognition of the importance of delivering on this agenda and making it a priority. Trust capacity and ability to collaborate. Alignment of partners priorities and strategies to improve population health. Developing role of ICS (future ICB) in management of population health and emergent strategy for health inequalities.			
Risk Appetite			**Risk Tolerance**			
Minimal (Clinical Safety)			Treat			

Controls	Last ReviewDate	Next ReviewDate	Reviewed by	Gaps in Control
1. Continued engagement with commissioners and ICS developments in clinical servicestrategies to prioritise, resource and facilitate more action on prevention and health inequalities.	***Jan-23***	***Mar-23***	B Kirton Dr S Enright J Murphy A Snell	Inability to measure equity of access, experience and outcomes for all groups in our community down to an individual level. There is a need for consistency and equity across the ICS so there is an ask for an equitable approach which is in development.
2. Partnership working at a more local level, including active participation in the Health Inequalities workstream, which will feed through the Integrated Care Governance (ICDG andup to the ICPG).	***Jan-23***	***Mar-23***	B Kirton Dr S Enright J Murphy A Snell	Insufficient granularity of plans to meet the needs of the population and the statutory obligations of each individual organisation. There is a need for a joined-up approach to be agreed across PLACE to ensure those people at the greatest risk of inequalities are able to access services to the same level of those that do not face barriers to accessing care. This requires close engagement with those living and working in these areas alongside the data analysis that is being undertaken.
3. All patients on the existing planned care waiting lists and those being booked for new procedures, are regularly assessed against the national clinical prioritisation standards (FSSA) as a minimum, taking into consideration individual patient factors pertaining to healthinequalities where possible.	***Jan-23***	***Mar-23***	B Kirton Dr S Enright J Murphy A Snell Dr J Bannister	Clinical Effectiveness Group re Clinical Prioritisation Process – FSSA Standards – was presented to CEG and approved ADoO (CBU 2) joined the meeting to assure the Group that there is a clinical prioritisation process in place. Defined priority levels are written by the Royal College of Surgeons and the FSSA to help define what priority patients are on the waiting list. The Group was assured with the pathway after the discussion and after seeing the report that was included in the papers.
4. Established population health management team that supports both the Trust, PLACE and is also linked to the ICS lead by a public health consultant.	***Jan-23***	***Mar-23***	B Kirton A Snell	None Identified - Public Health analyst capacity for BHNFT and Place Partnership has reduced since the response phase of the pandemic has ended.
5. Dedicated population health management team delivering Healthy Lives Programme covering tobacco and alcohol control.	***Jan-23***	***Mar-23***	B Kirton A Snell	None Identified
6. 35 key actions to influence health inequalities around 3 key factors: establish new services, enhance existing services & develop as Anchor institution. All within the health Inequalitiesaction plan, including using the vulnerability index to monitor access to care and an information sharing agreement with BMBC	***Jan-23***	***Mar-23***	B Kirton A Snell	Ongoing development and engagement regarding the vulnerability index to ensure fuller understanding of information and impact on trust processes across all business units, directors and Board

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
1. L1: Control 3 re clinical prioritisation reporting via IPR	Ongoing	Executive Team	Partial	Clinical prioritisation process needs to be re-reviewed at the Clinical Effectiveness Group to ensure ongoing evaluation of effectiveness.
2. L2: Presentation on Health Inequalities and the issues facing Barnsley, inc work to date and forward actions	Sep 22	Q & G Committee	Full	Quarterly updates on progress against the Improving Public Health and Reducing Health Inequalities Action Plan are provided to Q&G Committee, and this now includes action on the Cost of Living Crisis, including the establishment of a Trust CoLC working group.
3. L2: Presentation on Health Inequalities and the issues facing Barnsley, inc work to dateand forward actions	Jul 22	Board Strategic Focus Group	Full	Concerns given the economic downturn and its impact on to household income and the ability to live healthy lives consequently further increasing inequality. Workshop to explore with Trusts role in this in July 2022. The workshop went ahead and was aligned with a B2030 Board development session.
4. L3: PLACE Plan - system updates presented at PLACE Plan Care Board	Apr 22	PLACE Plan Care Board	Partial	Operational plan 2022/23 - work to the national direction around health inequalities, particularly elective recovery.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Development of a co-produced Health Inequalities priorities for the local integrated care system. Started Jan 21.	Sep-21	complete	A Snell	Complete
Control 2: Analysis of Barnsley demographics and its Index of Multiple Deprivation (IMD) profile. Started Oct 20.	Jan-21	Complete	A Snell	Complete
Control 2 and Assurance 4: Barnsley health inequalities plan based around the Stevens 8 urgent actions that is being built into the recovery plans for BHNFT and PLACE	Jul-21	complete	A Snell	Complete
Assurance 4: PHM team are conducting awareness sessions with teams and through the Trust governance to support the understanding of trust staff re health inequalities. Complete as below re Leadership Fellow against control 6.	Ongoing	In Progress	A Snell	Ongoing
Control 3 and Assurance 1: Clinical Effectiveness Group to receive clinical prioritisation process for review. Future reviews to include novel local approaches in development.	Sep-21	Complete	Dr S Enright	Mar-22
Control 4. Recruitment of a public health analyst hosted by BHNFT but co-funded by Place partners, with 50% capacity supporting BHNFT public health approach and 50% supporting place population health management	Mar-22	In progress	A Snell	Jan-23
Control 6 and Assurance 4. Leadership Fellow recruited to take the work forward on routine monitoring BHNFT activity against health inequality metrics and targeting BHNFT's core services to reduce health inequalities.	Mar-22	Complete	A Snell	Aug-23
Control 6 and Assurance 3. BHNFT has established its Anchor Institution Network Group working across the domains of its Anchor Charter and has supported BHNFT Board and Barnsley 2030 development sessions linking anchor principles to health inequalities in Barnsley.	Mar-22	Complete	A Snell	Mar-22
Control 6. BHNFT to lead the development of a Place Anchor Network, including health and care partners and organisations from other key sectors such as education.	Nov-21	In progress	A Snell	Feb-23

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2022/23: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	1693	Finance and Performance Committee	Director of Communications and Marketing	3x2	3x2	2527 - ineffective partnership working 1865 – zero-day vulnerability
Risk Description	**Consequence of Risk Occurring**		**Interdependencies**			
Risk regarding adverse reputational damage to the Trust There is a risk of reputational damage through different routes of exposure to the Trust.	The materialisation of this risk could impact patient choice, retention and recruitment of staff, potential financial income and regulatory compliance/action.		Wider system issues resulting in adverse publicity to other NHS service providers may result in increased media scrutiny of this Trust and / or its staff / services.			
Risk Appetite			**Risk Tolerance**			
Cautious (reputation)			Treat			

Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control
Comprehensive communications planner to track and plan for positive and potential adverse publicity	***Jan-23***	***Mar-23***	E Parkes	None identified
Monthly communications planner presented to the Executive Team	***Jan-23***	***Mar-23***	E Parkes	None identified
The Trust has a number of processes in place for the effective management of its overall reputation	***Jan-23***	***Mar-23***	E Parkes	None identified
Reactive statements prepared in advance for high risk matters	***Jan-23***	***Mar-23***	E Parkes	None identified
Proactive positive stories placed to counter negative publicity. Stakeholder briefings produced to inform of negative publicity (internal and external)	***Jan-23***	***Mar-23***	E Parkes	None identified

Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	Last Received	Received By	Assurance Rating	Gaps in Assurance
None identified				

Corrective Actions Required (include start date)	Action Due Date	Action Status	Action Owner	Forecast Completion Date
N/A	N/A	N/A	N/A	N/A

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	OPEN
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	MINIMAL
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	CAUTIOUS
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	OPEN
Regulatory / Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	CAUTIOUS
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK

Barnsley Hospital
NHS Foundation Trust

CORPORATE RISK REGISTER
JANUARY 2023

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life

Summary Corporate Risk Register – January 2023

CRR Risk ID	Risk Description	Date added to CRR	Executive Lead	Current Score	Last Reviewed	Strategic Objectives 2022/23	Strategic Goals and Aims	CRR Page No.
		Risk domain: Regulation / Compliance						
		Performance						
2592	Risk of inability to deliver constitutional and other regulatory performance or waiting time targets	May-21	Chief Delivery Officer	**15**	Jan-23	Best for Patients and the Public - we will provide the best possible care for our patients and service users	Patients and the Public/ Performance	Page 4
		Health and Safety						
2243	Risk regarding the aging fire alarm system	Mar-22	Managing Director of BFS	**15**	Jan-23	Operational risk	Patients and the Public	Page 5
		Risk domain: Reputation						
		Performance						
2813	There is a long-term gap in the maternity digital team impacting the data validity within the service	Nov-22	Director of Nursing & Quality	**15**	Jan-23	Operational risk	Patients and the Public	Page 6
		Risk domain: Clinical Safety / Clinical Effectiveness / Workforce						
		Service Delivery						
2803	Risk to the delivery of effective haematology services due to a reduction in haematology consultants	Jan-23	Medical Director	**16**	***NEW***	Operational risk	Patients and the Public / People	Page 7
		Risk domain: Finance / Value for Money/ Workforce						
		Workforce Costs						
1199	Inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	Nov-21	Director of Workforce/Director of Finance	**16**	Jan-23	Operational risk	Performance / People	Page 8
		Risk domain: Finance / Value for Money						
		Financial Stability						
2845	Inability to improve the financial stability of the Trust over the next two to five years	Jan-23	Director of Workforce	**16**	***NEW***	*To be confirmed at the Board of Directors in February 2023*	Patients and the Public / Performance/ Partner/ Place	Page 9

Strategic Objectives:

- Best for Patients and the Public – we will provide the best possible care for our patients and service users.
- Best for People – we will make out Trust the best place to work
- Best for Performance – we will meet our performance targets and continuously strive to deliver sustainable services
- Best for Partner – we will work with our partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways
- Best for Place – we will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
- Best for Planet – we will build on our sustainability work to date and reduce our impact on the environment.

Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	CAUTIOUS
Partnerships	SEEK
Innovation	SEEK

Risk 2592: Inability to deliver constitutional and other regulatory	C = 3 L = 5	**15**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
								Target score					*Initial score* *Current score*			

Risk description:	
There is a risk that the Trust will fail to deliver constitutional and other regulatory performance or waiting time standards / targets considering its capacity to cope with increased service demand anticipated over the coming year.	**Executive lead:** Chief Delivery Officer
	Date added to CRR: May 2021
	Last reviewed date: ***January 2023***
	Committee reviewed at: Finance and Performance Committee

Consequence of risk occurring
The materialisation of this risk will result in a breach in standards and potentially have an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm due to delays in access to care.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.		
Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET.	Unknown future demand for services may lead to surge in referrals above available capacity. Staff absence and vacancies are the biggest risk.	capacity gap identified in business planning & additional activity requirements discussed with finance director
Monitoring of activity of performance of NHSE/I (regulator) via systems meetings.		Development of Acute Federation & Integrated Care Board
Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	Impact on Health inequalities	Working to include health inequality data alongside waiting list management as per health inequalities action plan
Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	Moving to 12 hours from attendance at ED rather than decision to admit	Internal reporting has begun and patients waiting above 8 hours are reviewed by the CBU with appropriate escalation via patient safety processes

Risk 2243: Risk regarding the aging fire alarm system	C = 5 L = 3	**15**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score			*Initial score*				*Current score*			

Risk description:	
Failure of the fire alarm system causing temporary lack of early warning of fire in accordance with fire regulations.	**Executive lead:** Managing Director of BFS
	Date added to CRR: March 2022
	Last reviewed date: ***January 2023***
	Committee reviewed at: Health and Safety Group and Capital Monitoring Group

Consequence of risk occurring
The materialisation of this risk could result in harm or death in the subsequent event of a fire.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
System is maintained by the original installer and serviced regularly in accordance with current standards. As of 13/9/2022 all of the system is fully operational.	Availability of obsolete equipment – however, obsolete equipment is starting to become available as part of the replacement.	Maintenance in place, providing spare obsolete parts as appropriate. As project continues, more spares become available for older sections of system.
Site engineers are available with further on call/specialist contract available 24/7.		On-call Estates Engineers and contract with the fire alarm maintainer.
Temporary alternative arrangements for raising the alarm in place with associated SOP's and training given as appropriate should an area go off the system.		
Extra Security Patrols are available as required. Trained Fire Warden's in place across the site		
Firefighting equipment in place.		
Authorising Engineer (fire) aware of the strategy and fire risks for assurance and guidance purposes.		Regular review through the Fire Safety Group including the Fire Authorising Engineer.
South Yorkshire Fire Service are aware of the position.		Contact details to be established for the fire service.
Project to replace full alarm system commenced in April 2022. A programme has been fully prepared for the primary network, with detailed programme for individual zones being finalised as the project reaches the area due to the size of the project. Project anticipated to take circa 18 months.		Rolling programme of replacement in progress. Reports on progress received through Trust Capital Monitoring Group.

Risk 2813: There is a long-term gap in the maternity digital team impacting the data validity within the service	C = 3 L = 5	**15**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
								Target score			*Initial score*		*Current score*			

Risk description:	
There is a risk that the data quality of the monthly and quarterly dashboards contains inaccuracies due to long-term absence of the maternity digital team. IRIS dashboard requires data validation by Careflow audit due to inaccuracies.	**Executive lead:** Director of Nursing and Quality
	Date added to CRR: November 2022
	Last reviewed date: ***January 2023***
	Committee reviewed at: Quality and Governance Committee

Consequence of risk occurring
The materialisation of this risk will impact the Trust's reputation if inaccuracies are reported to external bodies.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Meetings have been held with the Trust digital team to request support however, there is limited current support available from the Principle Information Analyst due to maternity Careflow being managed by the maternity digital team only. There is no local maternity unit that uses Careflow that can support the Maternity Team.		
The existing digital team consists of 1.4 WTE. The Quality Safety and Governance Lead Midwife is currently managing this workload with the inpatient matron. Both have limited access to pull the audit reports from Careflow required to complete the dashboards.		
The target will be that the Trust and Maternity leads have wider knowledge of Maternity Careflow so if gaps were to occur in the Maternity Digital Team again this work could still continue. Once the Maternity Digital Team return a SOP is required and IRIS is to be reviewed to ensure increased accuracy to reduce the amount of data validation that is currently required. Further work is required produce the Yorkshire and Humber quarterly report via this system.		

Risk 2803: Risk to the delivery of effective haematology services due to a reduction in haematology consultants	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					*Initial score Current score*		

Risk description:	
There is a risk to the provision of an effective haematology service due to a reduction in consultant cover for Clinical Haematology, ward 24 and the chemotherapy unit. Consultant provision has reduced from 4 WTE to 2 WTE haematology consultants.	**Executive lead:** Medical Director
	Date added to CRR: January 2023
	Last reviewed date: ***New***
	Committee reviewed at: Quality and Governance Committee
Consequence of risk occurring	
The materialisation of this risk could impact on patient safety and experience.	

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
1. Substantive posts out to advert		
2. Locum support has been requested, with the possibility of 1 WTE cover from October to March. A further locum is required.		1.8 WTE Locum Consultant secured for October
3. Discussions with Rotherham Hospital regarding support being undertaken at Clinical Director level.		

Risk 1199: Risk regarding inability to control workforce costs	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9 *Target score*	10	12 *Initial score*	15	16 *Current score*	20	25

Risk description:	
There is a risk of excessive workforce cost beyond budgeted establishments which is caused by high sickness absence rate, high additional discretionary payments, poor job planning/rostering and high agency usage due to various factors including shortages of specialist medical staff.	**Executive lead:** Director of Workforce
	Date added to CRR: November 2021
	Last reviewed date: ***January 2023***
	Committee reviewed at: People Committee and Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk could result in financial over-spend impacting on quality of services and compromising patient care

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Sickness absence reduction plan, including occupational health referrals and counselling, health & wellbeing activity dashboards, monitored by the People and Engagement Group		
Job planning and rostering (AHPs, nursing and medical staff) – better job planning and rostering will mean a reduction in agency spend	£200k has been provided to implement an Electronic Rostering System for doctors, and funding commitments meant a percentage of junior doctors' rosters needed to bedelivered by March 2022 and this has been completed.	Roll out to juniors in General Medicine, Lower Surgery, Women's & Children's complete. Currently working on the build for Anaesthetics, then Emergency Medicine and higher surgery. Once all juniors complete will roll out leave management to SAS and Consultant levels.
National Procurement Framework and associated policies – compliance with these means we do not go over the agency caps. Supported by the Executive Vacancy / Agency Control Panel		
Reporting of Workforce Dashboard within Performance Framework – monitoring tool which provides an overview of workforce KPIs, including sickness absence information		
Nursing establishment reviews in conjunction with Finance, Workforce and E-Rostering Leads.		
Weekly medical establishment reviews in conjunction with Finance and Workforce.		
Risks relating to shortages of specialist medical staff (Dermatologists, Histopathologists and Breast radiologists) are managed through CBU governance arrangements.		

Risk 2845: Inability to improve the financial stability of the Trust over the next two to five years	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					*Initial score Current score*		

Risk description:	
There is a risk that the underlying financial deficit is not addressed resulting in the Trust being unable to improve it's financial sustainability and return to a breakeven position.	**Executive lead:** Director of Finance
	Date added to CRR: January 2023
	Last reviewed date: ***New***
	Committee reviewed at: Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk would adversely impact on the financial aspirations of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage; whilst hampering the delivery of Long Term Plan (LTP) ambitions. It would also mean the Trust being unable to realise a back-to-balance position, without external funding.

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Board-owned financial plans		
Achievement of the Trust's in-year financial plan and any control total (see risk 1713)		
Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings		
Delivery of the EPP programme recurrently		
Continued work on opportunities arising from PLICS / Benchmarking and RightCare.		
Continued discussions with SY ICB.		
Potential additional national and/or system resources become available		

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	OPEN
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	MINIMAL
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	CAUTIOUS
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	OPEN
Regulatory / Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of	CAUTIOUS

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
	compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK

BHNFT Risk Review/Approval Form (RISK2)

A * indicates and mandatory field.

Use the to open the dropdown list of values.

Click on for more information on relevant fields.

To use the spell check click on ; once you are finished with the spell check please click the icon to continue filling in the form.

Title and reference

Title	Inability to improve the financial stability of the Trust over the next 2 to 5 years
Reference	
Datix ID	2845

Risk Confirmation

Has this risk had the appropriate assessment before reporting onto Datix?	Yes
Date of assessment?	
Has this risk been approved by the relevant person within the triumverate?	Yes
Has this risk been approved by the lead owner?	Yes

Key Dates

Opened (date risk identified) (dd/MM/yyyy)	11/01/2023
Risk re-opened?	
Next review date (dd/MM/yyyy)	28/02/2023
Closed date (dd/MM/yyyy)	

Clinical or Non Clincal Risk

Clinical or Non Clinical Risk	Non Clinical

Approval status

Current approval status	Being reviewed
Lead/Owner	THICKETT, CHRISTOPHER - Director of Finance
Lead delegate	Paskell, Robert - Deputy Director of Finance

Risk details

Location

Clinical Business Unit (CBU)	Director of Finance
Specialty and Support Services	Not applicable
Location (type)	

Risk classification

Risk Type	Strategic Risk
Domain	Finance including claims
Source of risk	Meeting Paper Performance Data
Is this risk related to medical devices/equipment?	No

Description and Mitigation

Description	There is a risk that the underlying financial deficit is not addressed resulting in the Trust being unable to improve it's financial sustainability and return to a breakeven position. The materialisation of this risk would adversely impact on the financial aspirations of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage; whilst hampering the delivery of Long Term Plan (LTP) ambitions. It would also mean the Trust being unable to realise a back to balance position, without external funding.
Mitigation including controls	A range of control measures and mitigations are in place including: 1. Board-owned financial plans 2. Achievement of the Trust's in-year financial plan and any control total (see risk 1713) 3. Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings 4. Delivery of the EPP programme recurrently 5. Continued work on opportunities arising from PLICS / Benchmarking and RightCare. 6. Continued discussions with SY ICB. 7. Potential additional national and/or system resources become available
Consequence of Risk Occurring	
Interdependencies	
Adequacy of controls	Adequate
Last updated	KIMBERLEY TRAYNOR 11/01/2023 17:55:37

Is this risk linked to the BAF (Board Assurance Framework)

Is this risk linked to BAF (Board Assurance Framework)	Yes
Strategic Objective	
Oversight Committee	

Controls

No values

Gaps in controls

No values

Control

Last Review Date (control)	
Next Review Date (control)	
Review By (control)	

Assurances

No values

Gaps in assurances

No values

Assurance

Assurance rating
Assurances recieved
Last recieved (forum)
Received By

Progress Notes (New Note)

Progress Notes	Dec 22 - new risk as requested by F&P committee, splitting out the longer term financial risk from risk 1713. Risk scored as major consequence - due to uncertain delivery of key objectives, although it could be argued that the risk is greater than 1% of budget in which case the consequence would be catastrophic

Progress History (Any Progress from Previous Month)
Please copy and paste any previous updates from the progress notes above in this section

No progress notes.

Risk grading

Negligible	***Minimal injury requiring no/minimal intervention or treatment. No time off work. Peripheral element of treatment or service suboptimal informal complaint/injury. Short-term low staffing level that temporarily reduces service quality (<1day). No or minimal impact or breech of guidance/statutory duty. Rumours. Potential for public concern. Insignificant cost increase/schedule slippage. Small loss. Risk of claim remote. Loss/interruption of >1 hour. Minimal or no impact on the environment.**
Minor	*** Minor injury or illness, requiring minor intervention. Requiring time off work for up to 3 days. Increase in length of hospital stay by up to 3 days. Overall treatment or service suboptimal. Formal complaint (stage 1). Local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved. Low staffing level that reduces the service quality. Breech of statutory legislation. Reduced performance rating if unresolved. Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met. <5% per cent over project budget. Schedule slippage. Loss of 0.1-0.25 per cent of budget. Claim less than £10,000. Loss/interruption of >8 hours. Minor impact on environment**
Moderate	*** Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients. Treatment or service has significantly reduced effectiveness. Formal complaint (stage 2). Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on. Late delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (1> day) Low staff morale. Poor staff attendance for mandatory/key training. Single breech in statutory duty. Challenging external recommendations/improvement notice. Local media coverage – long term reduction in public confidence. 5-10 per cent over project budget. Schedule slippage. Loss of 0.25-0.5 per cent of budget. Claim(s) between £10,000 and £100,000. Loss/interruption of >1 day. Moderate impact on environment.**
Major	*** Major injury leading to long-term incapacity/disability. Requiring time off work for more than 14 days. Increase in length of hospital stay by more than 15 days. Mismanagement of patient care with long-term effects. Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/independent review. Low performance rating. Critical report. Uncertain delivery of key objectives/service due to lack of staff. Unsafe staffing level or compliance (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training. Enforcement action. Multiple breeches in statutory duty. Improvement notices. National media coverage with <3 days service well below reasonable public expectation. Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Loss 0.5-1.0 percent of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time. Loss/interruption of >1 week. Major impact on environment.**
Catastrophic	*** Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients. Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman injury. Gross failure to meet national standards. Non delivery of key objective/service due to lack**

	of staff. Ongoing unsafe staffing levels or competence. Multiple breeches in statutory duties. Prosecution. Complete systems change required. Zero performance rating. Severely critical report. National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in House) Total loss of public confidence. Incident leading >25per cent over project budget. Claim(s) >£1 million. Permanent loss of service or facility. Catastrophic impact on environment.

Initial (Inherent)

	Consequence (initial)				
Likelihood (initial)	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain	○	○	○	○	○
Likely	○	○	○	◉	○
Possible	○	○	○	○	○
Unlikely	○	○	○	○	○
Rare	○	○	○	○	○
	Rating (initial): 16 **Risk level (initial):** Extreme Risk (15-25)				

Current (Residual)

	Consequence (current)				
Likelihood (current)	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain	○	○	○	○	○
Likely	○	○	○	◉	○
Possible	○	○	○	○	○
Unlikely	○	○	○	○	○
Rare	○	○	○	○	○
	Rating (current): 16 **Risk level (current):** Extreme Risk (15-25)				

Change of Current Score
If you have re-scored the risk. Please attach Revised risk assessment or give an explanation to the re-scoring of the risk.

Target

	Consequence (Target)				
Likelihood (Target)	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain	○	○	○	○	○
Likely	○	○	○	○	○
Possible	○	○	○	○	○
Unlikely	○	○	○	◉	○
Rare	○	○	○	○	○
	Rating (Target): 8 **Risk level (Target):** High Risk (8-12)				

Date for Target Risk to be Achieved

Identifyer of risk

	Approval status	Title	Forenames	Surname	Date of birth	Patient unit number	NHS No.	Type	Status	Contact role
▶	Approved		KIMBERLEY	TRAYNOR				Employee/Member of Staff		Reporter

Actions

No actions

Communication and feedback

Recipients

Message

Message history				
Date/Time	**Sender**	**Recipient**	**Body of Message**	**Attachments**
No messages				

Documents

No documents.

Linked records
Highlight whether the risk is linked to another BAF risk or corporate risk as detailed on the Corporate Risk Register.

No Linked Records.

4.2. Standards of Business Conduct and Managing Conflicts of Interest Policy Angela Wendzicha Interim Director of Corporate Affairs

For Assurance/Approval

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/4.2

SUBJECT:	**STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST POLICY**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Gilbert George, Interim Director of Corporate Governance				
SPONSORED BY:	Richard Jenkins, Chief Executive Officer				
PRESENTED BY:	Angela Wendzicha, Interim Director of Corporate Affairs				

STRATEGIC CONTEXT

This paper falls under Strategic Objective 4: People will be proud to work for us.

EXECUTIVE SUMMARY

The Trust's Standards of Business Conduct had not been revised since January 2017. Whilst it still operates effectively, it is appropriate that it should be updated to reflect the most recent NHSE guidance. The revised policy is based on the model policy as provided by NHSE.

Following review by the interim Director of Corporate Governance and discussion at the Audit Committee, only minor amendments have been recommended (edits tracked changed).

The Audit Committee recommended approval of the updated policy by the Trust Board.

RECOMMENDATION

The Board of Directors is requested to approve the updated Standards of Business Conduct and Managing Conflicts of Interest Policy, as recommended by the Audit Committee.

Next review will take place in two years' time or whenever NHSE or other statutory legislation is reviewed, whichever is sooner.

Standards of Business Conduct
and
Managing Conflicts of Interest Policy

Policies should be accessed via the Trust internet to ensure the current version is used.

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1. INTRODUCTION

NHS England (NHSE) has provided guidance to NHS Bodies regarding "*Managing Conflicts of Interest in the NHS – Guidance for staff and organisations*" (Publications Gateway Reference: 06419).

Barnsley Hospital NHS Foundation Trust (the 'organisation'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

2. SCOPE

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

This policy should be considered alongside other organisational policies listed at the end of the document.

3. POLICY STATEMENT

The policy has been produced to assist staff in maintaining strict ethical standards in the conduct of NHS business. The following information and guidance must be noted and adhered to by all staff. Recognising that statements of this nature cannot allude to every possible contingency, it is assumed that all staff are able to distinguish between acceptable and unacceptable behaviour in the conduct of their duties. If, however, staff are uncertain about the correctness or propriety of any proposed business transactions, or in relation to hospitality, declaration of interests and commercial sponsorship then they must seek guidance from their line manager in the first instance.

It is a long established principle that public sector bodies, including the NHS, must be impartial and honest in the conduct of their business and their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an employee corruptly, to accept any inducement or reward for doing or refraining from doing anything in her/his official capacity. A breach of the provisions of these Acts renders employees liable to prosecution and may also lead to loss of their employment and pension rights in the NHS.

This policy is applicable to board members, governors, employees, and agency staff. The Director of Corporate Affairs and Line Managers will be responsible for ensuring that the contents are brought to the attention of all listed above on a regular basis.

4. DUTIES AND RESPONSIBILITIES

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff'.

Decision making staff in this organisation **include, but not limited to**:

- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions

4.1. Trust Board

The Trust Board has responsibility for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents

4.2. Governors

The Governors have responsibility for:

- Holding the non-executive directors individually and collectively to account for the performance of the board of directors.
- Representing the interests of the members of the NHS foundation trust and the public.
- Approving 'significant transactions', mergers, acquisitions, separations or dissolutions

4.3. Chief Executive

The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that Trust process documents comply with all legal, statutory and good practice guidance requirements.

4.4. Director of Workforce

The Director of Workforce maintains the register of secondary employment monitoring in relation to the Working Time Directive and secondary employment declarations.

4.5. Director of Corporate Affairs

The Director of Corporate Affairs is responsible for ensuring that:

- The document is drafted, approved and disseminated in accordance with the Trust policy.
- The necessary communication methods required to implement this policy are identified and resourced or built into the delivery planning process.
- Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this policy.

4.6. Line Managers

Line managers must ensure their staff adhere to this policy and in particular follow the procedures for declarations of interests, gifts and hospitality, sponsorship and secondary employment.

4.7. Employees

At Barnsley Hospital NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

All staff are responsible for:

- Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken.
- Co-operating with the development and implementation of policies and procedures as part of their normal duties and responsibilities.
- Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager.
- Attending training/awareness sessions when provided.

5. PROCEDURES

- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

5.1. Conflicts of Interest

A conflict of interest is defined as "a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold".

5.1.1. A conflict of interest may be:

Actual	Potential
There is a material conflict between one or more interests	There is the possibility of a material conflict between one or more interests in the future

5.1.2. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of allegation of improper conduct.

5.1.3. Interests can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision.

Interests fall into the following categories:

Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests
Where an individual may get direct financial benefit* from the consequences of a decision they are involved in making	Where an individual may obtain a non-financial professional benefit* from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career	Where an individual may benefit* personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career	Where an individual has a close association** with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit* from a decision they are involved in making

* A benefit may arise from the making of gain or avoiding a loss.
** These associations may arise through relationships with close family members and relatives,

close friends and associates, and business partners. A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.

5.1.4. If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

5.2. Gifts

Situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way.
A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.

The overarching principle applying in all circumstances is that staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Where amounts* or values* have been stated in this policy they have been taken from NHSE guidance – selected by NHSE with reference to existing industry guidance issued by the ABPI with the exception of the value for gifts which the organisation has decided to retain at £25.

Principles and Rules

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value.
- Subject to this, low cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6* in total, and need not be declared.

Gifts from others sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £25 should be treated with caution and only be accepted on behalf of an organisation (i.e. to an organisation's charitable funds), not in a personal capacity, unless there is an exceptional circumstance (see below). These should be declared by staff.
- Modest gifts accepted under a value of £25 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £25 where the cumulative value exceeds £50.

All appropriate gifts accepted must be declared by the staff member on the declarations of interest form at Appendix 1.

Exceptional Circumstances

Any offer of a gift where the situation is not straightforward in line with the above, e.g. where the proposed gift is not personal to one individual or where to refuse a gift offered by a patient or their family may cause offence, should be discussed in advance with the Director of Corporate Affairs, e.g. if a patient buys a gift to be used in a specific service area. If, following discussion, it is deemed appropriate to accept the offer of the gift; a declaration form should be completed and returned to the Director of Corporate Affairs who will add it to the register. Any declaration should be discussed with and approved by your line manager.

5.3. Hospitality

Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted, and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.

Principles and Rules

Overarching principles applying in all circumstances:

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors – these can be accepted if modest and reasonable but individuals should always obtain senior approval and declare these.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75* – may be accepted and must be declared.
- Over a value of £75* - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept travel and

accommodation of this type.

- A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel).
  - offers of foreign travel and accommodation.

5.4. Private Clinical Opinion and other Similar Arrangements

Where a Trust employee or those where the Trust funds their activity, are asked to provide a private clinical opinion and/or report then the activity and income must be declared as follows:

- Where the clinician takes the time as annual leave or undertakes the activity outside of contracted work time with the Trust, then they must declare the income to the Director of Corporate Affairs and as additional income to the Inland Revenue.

  In such cases the clinician must make it clear that they are providing the review and/or report in their own private clinical capacity. They must not use Trust resources in the preparation of materials. They must not use their Trust employee privileges to access records or information other than to request them as an external agent and making any necessary payment. They must not use other Trust staff's time or other resources to construct the report. They must not provide the report on Trust letterhead or imply in any way that they are undertaking work for or on behalf of the Trust or as part of their employment with the Trust. Doing so is regarded as a breach of contract and a disciplinary matter.

- Where the clinician provides any such opinion as agreed with their Line Manager as part of their duties then any fees received must be paid into the appropriate Trust budget.

- Where employed staff provide private clinical opinion and/or court reports they should ensure that this work is covered by or secure individual professional indemnity insurance that covers liability risks pertaining to these reports. This activity being private falls outside Trust business and the Trust cannot accept any liability in connection with it and/or them.

- In this context private clinical opinion and/or court reports include any witness statement(s) submitted to court for private fee payment. Therefore in essence any evidence (written or attending court in person to give oral evidence) is covered herein and is outside of the indemnity arrangements of the organisation.

Any employed member of staff sending evidence to court must be aware that they are thereby offering to be a witness and immediately expose themselves to be called to attend (even by witness summons/subpoena). As court hearings can be listed for full days, or a number of days, this potentially means that witness' may not be able to fulfil their contractual obligation to be available to attend to NHS duties. In such cases, where the statement has been made as an employee, then the line manager must make arrangements for availability and backfill. Where this is as a result of private opinion the employee must make their line manager aware of their absence which must be taken as leave (paid or unpaid). In extreme cases the line manager may consider this a breach of contract if it causes significant problems and/or expenditure to backfill normal employee duties and the employee has rendered themselves unavailable by giving their private opinion.

5.5. Declarations and Potential Conflict of Interest

Where other types of work have been undertaken (e.g. writing on behalf of a company for a sponsored publication) a declaration must be made (Appendix 1). This is the case even if the work has been commissioned and undertaken in the employee's own time and where any payment is a matter for the employee and the sponsor and where the employee is responsible for any financial declaration to HMRC.

This is because there is still the potential for a conflict of interest to arise relating to Trust business

and the persons status as an employee. For example, publications sponsored by companies where by that company's products are used in the work context. In such cases, the employee should declare their interest and withdraw from the discussion or the senior officer present must ensure that their continued involvement does not compromise or overtly influence the process.

5.6. Secondary Employment and Outside Interests

The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.

Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation. (Clinical private practice is considered in a separate section).

Declarations of secondary employment should be made on an annual basis to the Human Resources Department. Forms are available on the Intranet.

Principles and Rules:

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest is identified, the general management actions outlined in this guidance should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from an organisation to engage in outside employment.
- Organisations may also have legitimate reasons within employment law for knowing about outside employment of staff, even this does not give rise to risk of a conflict. Nothing in this guidance prevents such enquiries being made.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

5.7. Private Practice

Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves.

Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be managed. These provisions around declarations of activities are equivalent to what is asked of all staff in the section on Outside Employment.

Principles and Rules:

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including:

- where they practise (name of private facility)
- what they practise (specialty, major procedures)
- when they practise (identified sessions/time commitment)

*Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003 https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf.

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work. **
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf.

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on his or her behalf. **

** These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf).

Where clinical private practice gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

What should be declared?

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when you practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

5.8. Commercial Sponsorship

Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result there should be proper safeguards in place to prevent conflicts occurring.

Principles and Rules:

- Sponsorship of events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the organisation and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At an organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.
- Organisations should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff should declare involvement with arranging sponsored events to their organisation.

Organisations should maintain records regarding sponsored events in line with the above principles and rules.

Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.

Principles and Rules:

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to their organisation.

What should be declared?

- Organisations should retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
  - their name and their role with the organisation
  - a description of the nature of the nature of their involvement in the sponsored research
  - relevant dates
  - any other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance)

Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

Principles and Rules:

- Staff who are establishing the external sponsorship of a post should seek formal prior approval from their organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

Organisations should retain written records of sponsorship of posts, in line with the above principles and rules.

Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this guidance.

5.9. Wider Transparency Initiatives

Barnsley Hospital NHS Foundation Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

5.9.1. Benefits, Risks and Principles

There are potential benefits and risks associated with sponsorship, e.g.:

Benefits	Risks
Income generation or expenditure avoidance	Financial loss
Promotion of the Trust	Adverse publicity. e.g. through association with discredited company or product
Beneficial alliances with commercial sponsors	Loss of control by being beholden to another party

The principles upon which any sponsorship arrangements are based must enhance benefits and minimise risks, such that:

- The Trust must not be seen to endorse firms or products; disclaimers are essential
- Sponsorship must not damage the image of the Trust
- Suppliers of products suspected or known to be harmful to health will not be accepted

- Where possible potential sponsors should be given the opportunity to compete
- The Trust will not be involved in the promotion of specific branded drugs
- Trust staff must not allow their professional status or qualifications to be used in the promotion of commercial products or services.
- Sponsorship arrangements must not breach the legal duty of confidence.

5.10. Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour – which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

5.11. Shareholdings and other Ownership Issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policyshould be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

What should be declared?

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.12. Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc., where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared?

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

5.13. Loyalty Interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

What should be declared?

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.14. Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared?

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

6. DEALING WITH BREACHES

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

6.1. Identifying and Reporting Breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to their line manager in the first instance and the Director of Corporate Affairs.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the NHS.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation, the organisation will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

6.2. Taking Action in Response to Breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Workforce Department), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include:
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

6.3. Learning and Transparency Concerning Breaches

Reports on breaches, the impact of these, and action taken will be considered by the Executive Team (ET) and if appropriate the Workforce Department as they arise

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Trust's website as appropriate, or made available for inspection by the public upon request.

7. TRAINING REQUIREMENTS

There are no specific training needs in relation to this policy, but as a Trust Policy, all staff need to be aware of the key points the policy covers. Staff can be made through local induction, team meetings and communication emails.

8. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

9. BRIBERY ACT

The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed.

The penalties for any breaches of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed and an individual convicted of an offence can face a prison sentence of up to 10 years.

For further information see https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-guidance.pdf. If you require assistance in determining the implications of the Bribery Act please read the Trust Fraud, Bribery and Corruption Policy available on the intranet or contact the Director of Corporate Affairs on 01226 431 818. Alternatively, you can contact the Trust's Counter Fraud Specialist 07920 138354 or the Counter Fraud Authority on 0800 028 40 60 or www.cfa.nhs.uk.

10. IMPLEMENTATION

This policy will be disseminated by the method described in the Policy for the Development and Management of Procedural Documents.

This is a revised policy following publication of new guidance it will be implemented within existing resources.

The risk of not having this document is that the Trust will not be compliant with NHSE Guidance for all Trusts.

10.1. Publication

We will:

- Publish the interests declared by decision making staff on our website via Civica Declare
- Publish the register of gifts and hospitality made by staff on our website via Civica Declare

- Make this information available on our website https:barnsleyhospital.mydeclarations.co.uk

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact their line manager or the Director of Corporate Affairs to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference. The final decision will be made jointly between the line

manager and Director of Corporate Affairs.

11. MONITORING AND AUDIT

Minimum Requirement	Frequency	Process for monitoring	Evidence	Responsible Individual(s)	Response Committee(s
Reminder to staff of requirements within the policy	Annually	Annual review of Registers	Report produced	Director of Corporate Affairs	Audit Committee Trust Board
Publication on website	Ongoing	Annual report to Audit Committee	Report produced	Director of Corporate Affairs	Audit Committee Trust Board

Monitoring of the implementation of this policy will be through the annual report to the Audit Committee. An annual report will be submitted to show the number of declarations of gifts, hospitality and sponsorship that have been made. ET will review any declarations of sponsorship.

This document will be reviewed in two years' time or whenever NHSE or other statutory legislation is reviewed, whichever is the sooner.

12. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

- Managing Conflicts of Interest NHS England/NHS Improvement Freedom of Information Act 2000
- ABPI The Code of Practice for the Pharmaceutical Industry (2014) ABHI Code of Business Practice
- NHS Code of Accountability
  Bribery Act 2010
- Data Protection Act 1998
- Freedom to Speak Up: Raising Concerns (whistleblowing) Policy for the NHS Trust Constitution
- Standing Orders, and Standing Financial Instructions
- Reservation of Powers to the Trust Board and Scheme of Delegation
- Ethical Code of the Chartered Institute of Purchasing and Supply – Sept 2013

13. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

- Working Time Regulations Policy
- Counter Fraud, Bribery and Corruption Policy.
- Charitable Funds Procedures Handbook
- Raising Concerns at Work Policy and Procedure
- Codes of Professional Conduct
- Codes of Conduct and Accountability for NHS Boards
- BHNFT Recruitment and Selection Policy and associated procedures
- BHNFT Study Leave Policy

5. Business Case/Benefits Paper

5.1. Mexborough Elective Orthopaedic Centre

For Assurance/Approval

Presented by Bob Kirton

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/02/02/5.1

SUBJECT:	**Mexborough Elective Orthopaedic Centre (MEOC)**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	
	For review	✓		*Governance*	✓
	For information			*Strategy*	✓
PREPARED BY:	James Townsend – ADO Operational Recovery				
SPONSORED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive				
PRESENTED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive				

STRATEGIC CONTEXT

This paper is in line with the national Operational Planning Guidance and the Elective Recovery Guidance in reference to recovery of operational mandated standards.

Locally, this this paper is also aligned with the Trusts 2022-27 ambitions and strategic objectives, with a focus on the delivery of our six 'P's:

- Patients and Public
- People
- Performance
- Best Partners
- Place
- Planet

EXECUTIVE SUMMARY

Overview/Operational Model

Colleagues from Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH), Barnsley Hospital NHS Foundation Trust (BHNFT) and The Rotherham Hospital NHS Foundation Trust (TRFT) have been working in partnership, alongside the Acute Federation, for an extended period of time to discuss the development of a dedicated Orthopaedic elective hub based on the Montagu hospital. The business case process is included further on.

The proposed Montagu Elective Orthopaedic Hub (MEOC) will be a dedicated 'green' facility designed to see and treat orthopaedic patients across partner organisations within the South Yorkshire ICB e.g. DBTH, BHNFT and TRFT.

The project management/coordination of the MEOC development is led by DBTH, but developed in collaboration with BHNFT and TRFT. Strategically, the vision is that the operational leadership of the service will be via a partnership approach, with the on-going estates management supported via DBTH.

The proposed facility will operate as follows:

- 48 weeks of the year
- 5 days per week
- 2 x 4-hour sessions per day
- 2 x theatres
- 12 x inpatient beds which will be operational 24hrs a day, 7 days a week
- 4 x stage 1 recovery beds

Notionally, overall elective capacity will be allocated 50% to DBTH and 25% each to BHNFT and TRFT, with an annual review (this is based on existing waiting list sizes and demand across the partner organisations).

To note there is scope to expand into evening and weekend working as per GIRFT recommendations e.g. 2.5 session days, 6 days a week. GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

The proposed 'go live' date for the proposed new facility is the 23rd October 2023.

Benefits

The overall benefits of the proposed MEOC facility are outlined on page 5 of the business case. The key benefits for BHNFT are as follows:

- Create additional elective orthopaedic capacity – helping to treat patients in a timelier manner and reduce waiting lists.
- Opportunity to pre-plan and include the proposed new capacity for the Orthopaedic service within the 2023/24 business planning process.
- Releases capacity and funding at host sites for maintaining existing provision of orthopaedics, further supporting the overall elective recovery of the service.
- Will support future winter planning by providing ring-fenced elective bed capacity on a 'green' facility - mitigating cancellations or closure of the service as a consequence of non-elective pressures.
- Strategically located close to the Dearne area of Barnsley – will support access to care and reducing health inequalities.
- Greater patient choice in terms of where elective surgery is undertaken.
- Positive levels of patient and staff satisfaction through consistent and predictable processes, excellent communications and training and specialisation opportunities.
- Strategic alignment in reference to the Trusts objectives e.g. best partners, patients and public etc.
- Implementation of best practice GIRFT care pathways with standardised peri-operative care and preassessment co-designed with clinicians to reflect management of care between hosts sites and MEOC.

Issues for Consideration

The below represents the key issues for consideration associated with the project:

- Financial impact from a revenue perspective – see page 29 for revenue assumptions, but in practice how this will work across the partner Trusts. Greater detail is required and would need to be supported via a contract and a Memorandum of Understanding (MoU).
- The clinical and operating model - ongoing discussions to formulate and agree across

partner Trusts ensuring effective clinical engagement with all teams.
- Request from DBTH re. releasing clinical stakeholders one day a week throughout Q4 to develop the clinical and operating model.
- The business case governance process and timeline to meet the national submission date. (see below)
- Patient engagement/consultation and the movement of patients from BHNFT to Montagu

Finance

The financial overview of the proposed development can be seen on page 14 and 15.

Capital will be funded via the national TIF scheme and presents no associated risk to the Trust.

From a revenue perspective, next steps include. agreeing the clinical model and robust demand and capacity profiling across partner organisations prior to approval.

The financial sustainability of the service is paramount. In the short term it is anticipated that funding will be achieved via the Elective Recovery Fund (ERF). Longer term, it is pivotal that the usage of the proposed unit is based on demand – assuming demand is less than capacity, this may involve a lift and shift approach from Barnsley to Montagu or a reduction in weekend theatre sessions to mitigate any additional spend.

Governance Sign Off

The overall governance process requires business case sign off and letters of support from the following:

- DBTH Board - approval on the 20th December 2022
- BHNFT ET - approval on the 4th January 2023
- TRFT ET - approval on the 22nd December 2022
- Doncaster, Rotherham and Barnsley PLACES – agreement in principle required
- South Yorkshire Acute Federation
- South Yorkshire ICB - approval in principle on the 4th January 2023 subject to Trust Board minutes supporting the direction of travel.
- NHSE Regional Team - approval in principle on the 12th January 2023 subject to Trust Board minutes supporting the direction of travel.
- NHSE – going to the national team for consideration on the 19th January 2023.

From a BHNFT perspective the proposed governance approval process is as follows:

- Executive Team – 4th January 2023 (approved)
- Finance and Performance – 26th January 2023 (approved)
- Board – 2nd February 2023

Locally, the concept of the Elective hub was discussed at Barnsley PLACE Board on the 10th January 2023, generally supportive but requires assurance from a revenue perspective which is being picked up by local commissioners within the ICB.

To note, the governance sign-off process associated with this development is a nationally mandated format by NHSE/I.

Risk Register

There are two risks on the CBU2 risk register that are relatable to this type of development – risk

2843 (RTT long waits) and 2844 (mutual aid), both scoring a 12 on the risk matrix.

The development of the MEOC will support the mitigation plan of both risks.

Next Steps

As agreed by ET on the 4th January 2023 and F&P on the 26th January 2023, the next steps are as follows:

- Approved the capital expenditure but revenue would need to be reviewed and agreed following the agreement of the clinical model and based on activity demand.
- Submit the business case to Board on the 2nd February 2023 requesting support.
- Request support for the business case from Barnsley PLACE.
- A greater understanding and transparency of the revenue implications, supported via a MoU which is agreeable by DoFs from partner Trusts.
- Agree and confirm the staffing model for the new facility.
- Agree and confirm the operational and management arrangements
- Clinical and operational stakeholders to support the development of the clinical and operating model.

In order to manage and support the initiative locally the recommendation is to create an executive led project steering group, with a view to commence in January 2023. This will ensure Trust stakeholders have the opportunity to be involved in the decision making of the service, its operational model, whilst supporting communication across the Trust at all levels.

RECOMMENDATION

The Board of Directors is asked to:

- Note the business case and direction of travel towards the development of a dedicated 'green' site for Orthopaedic electives.
- Endorse the partnership working arrangement between the three Trusts.
- Support the capital spend associated with the business case, whilst recognising further work is required in terms of the revenue.

Routine updates will be presented to ET as the project progresses for oversight, assurance and where required decision-making.

Montagu Elective Orthopaedic Centre (MEOC)
Short Form Business Case Template
£5m - £15m Schemes

SECTION 1: SCHEME OVERVIEW

SCHEME DETAILS

PROJECT DESCRIPTION	Region:	North East & Yorkshire
	STP / ICS Name:	South Yorkshire
	Lead Organisation for the Scheme:	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH)
	Title of the Scheme:	Montagu Elective Orthopaedic Centre (MEOC)
	One Line Description of the Scheme:	A ring-fenced hub for high volume low complexity (HVLC) orthopaedic day case and inpatient activity.
	Specific Sites for Investment:	Montagu Hospital, Mexborough
	Other Organisations Impacted by this Scheme:	The Rotherham Hospital Foundation (TRH) Trust and Barnsley Hospital Foundation Trust (BH)

BRIEF SCHEME OVERVIEW

Summarise the key dimensions of the scheme in terms of the outputs that will be enabled in service terms as a consequence of the investment.

MEOC is a proposed investment in a 'cold site', ring fenced, elective orthopaedic hub with dedicated beds, theatres and staffing delivering waiting list and waiting time reductions for patients in line with the Elective Recovery Plan (ERP). DBTH has developed the business case on behalf of the ICS together with its partners The Rotherham Hospital Foundation (TRH) Trust and Barnsley Hospital Foundation Trust (BH). Future developments may include capacity for Sheffield patients, potentially including paediatric activity. The partners and ICS see this Targeted Investment Fund (TIF) investment as a 'Proof of Concept' and have a broader vision for an Elective Orthopaedic Centre of Excellence in the future.

The main aims of the MEOC investment are:

- To reduce elective orthopaedic waiting lists and waiting times
- Improve productivity and efficiency
- Increase quality and effectiveness of surgical interventions
- Improve access and eliminate cancellations due to bed pressures

The facility will deliver inpatient and day case activity:

- Inpatient activity will focus on HVLC hip and knee arthroplasty targeted at increasing numbers of 0 and 1 day discharges against a current average of 2.75 day length of stay for these patients.
- Day case activity will include upper limb, shoulder, hand, wrist, foot and ankle surgery together with various other 'filler' interventions such as injections and carpal tunnels.

The breakdown of activity proposed for the first full year of operation is as follows:

Procedure	IP/DC	Activity			
		Barnsley	Doncaster	Rotherham	Total
Hand & Wrist	DC	20	252	312	584
Foot & Ankle	DC	66	104	37	207
Arm & Shoulder	DC	165	136	0	301
Carpals	DC	0	72	0	72

Injections	DC	0	168	0	168
DC Sub Total		**251**	**732**	**349**	**1332**
Knee	IP	116	315	132	563
Hip	IP	83	162	108	353
Other	IP	40			40
IP Sub Total		**239**	**477**	**240**	**956**
Grand Total		**490**	**1209**	**589**	**2288**
Percentages		**21%**	**53%**	**26%**	**100%**

The opening hours for the theatres will be:

- 48 weeks per year
- 5 days per week
- 2 (4 hour) sessions per day

Beds will be open 24 x 7 x 365.

The productivity of the unit shown above is based on agreement between lead clinicians across the three partner providers who have expressed cautious views around what is possible when the facility opens. However, GIRFT guidance recommends a 6-day week (increasing activity to 2745 cases per annum) and 2.5 sessions per day (increasing activity to 3431 cases per annum). Additionally, the basis for lower limb arthroplasty is 4 cases per 8-hour list and some of the best performing surgical hubs are delivering more than this. Our aspiration is to move to higher levels of productivity over time as the service becomes embedded.

The facility, based at Montagu Hospital, Mexborough, will include:

- two new modular lead lined and laminar flow operating theatre suites adjacent to the existing Rehabilitation Block, with dedicated access and reception.
- An improved link to the main hospital to provide direct access to the existing Rockingham Day Case Unit admission and discharge lounge facilities, incorporating a new platform lift.
- 14 existing bedspaces will be refurbished to create 12 orthopaedic inpatient beds, and further internal works will create new staff change and storage areas with remaining areas to be retained for rehabilitation services.
- The future Mexborough Development Control Plans include provision for an extension to the MEOC project, hydrotherapy pool, and Clinical Diagnostic Centre, supported by a revised site and road layout, extended car parking, and infrastructure development.

The key benefits delivered by MEOC include:

- Ring-fenced elective bed capacity on a ‘cold-site’ preventing cancellations due to medical outliers.
- Greater throughput for hip and knee arthroplasties through increasing the number of 0 & 1 day discharges.
- Released capacity at host sites for maintaining existing provision of orthopaedics to ensure that MEOC workload is additive.
- Implementation of best practice GIRFT care pathways with standardised peri-operative care and preassessment co-designed with clinicians to reflect management of care between hosts sites and MEOC.
- Elimination of on the day cancellations through consistent and coordinated pre-assessment processes.
- Standardisation of equipment and consumables to minimise unwarranted variation in practice and improving cost effectiveness.
- Very high levels of patient and staff satisfaction through consistent and predictable processes, excellent communications and training and specialisation opportunities.

LEAD ORGANISATION DETAILS		
SENIOR RESPONSIBLE OFFICER (SRO) DETAILS	Title	Deputy Chief Executive
	Name	Jon Sargeant
	Organisation	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
	Office tel.	01302644147
	Mobile tel.	07949 490162
	e-mail	jonathan.sargeant@nhs.net

APPENDICES CHECKLIST	
APPENDIX	**COMPLETED / ATTACHED (Y/N)**
Appendix 1 – Programme Specific monitoring and reporting	Y
Appendix 2 – Schedule of Works	Y
Appendix 3 – OB Forms	Y
Appendix 4 – Key Estates Information	Y
Appendix 5 – Equality impact assessment	Y
Appendix 6 – Letters of Support	N*
Appendix 7 – Digital capability KLOEs	Y

*Letters of support will be procured and attached as this final draft business case is reviewed and approved through local ICS governance.

SECTION 2: PROGRAMME SPECIFIC INFORMATION REQUESTS	
ELECTIVE RECOVERY BENEFITS - Please provide detail of the anticipated benefit of the scheme on Elective Recovery: (Separation of activity; Demand Management; Elective 'Long Waiters', and the Cancer 62 Day Backlog)	
ELECTIVE RECOVERY BENEFITS Please provide a description of the anticipated Benefit of the Scheme on Elective Recovery, Demand Management and Elective 'Long Waiters', and the Cancer 62 Day Backlog	1. Geographical separation of the elective activity from the acute and emergency pathways through a 'cold-site' facility at Montagu Hospital Mexborough. 2. Good accessibility for patients from host Trusts due to central location and excellent parking facilities. 3. A ring-fenced surgical hub dedicated to the orthopaedic IP/DC elective pathway only. 4. Co-located facilities within the hub, dedicated to orthopaedics and not shared with competing demands. 5. Dedicated staffing for the entire pathway within MEOC but with outpatients and pre-assessment delivered at host sites for local access. 6. Optimised peri-operative process including 'active wait' targeted support to reduce cancellations and increase timely discharge 7. Standardised preassessment processes, carried out by the same teams delivering the surgery, to eradicate on the day cancellations. 8. Designed for good flow, reducing delays and waste in terms of the facility layout, staffing types/levels and SOPs 9. Best practice GIRFT pathways including an MDT approach, pre-operative planning, standardised pathways, so reducing length of stay and increasing day cases. 10. 8-hour operating days, 5 days per week, 48 weeks per year with the aim to increase once embedded. 11. Efficient theatre process designed to maximise knife to skin time and remove delays. 12. Theatre equipment for the unit so that it does not have to be shared with the trauma or other elective services on another site. 13. Standardisation of equipment and consumables to reduce training, costs and risk of error. 14. Transport arrangements to support 'hard to access' patients. 15. Digital solutions to support booking and sharing of patient information to include results and images across partner providers. 16. Dedicated radiography support with back up of on-site radiology team.
TYPE OF SCHEME Please specify the intended output that this scheme intends to deliver.	Surgical Hubs / Theatre Block
BEDS / THEATRE CAPACITY CREATED Please set out the number of additional beds (specifying whether these are protected elective, non-elective or critical care beds) or theatre capacity created by the scheme.	**Beds** 12 additional, dedicated orthopaedic beds co-located with theatres with dedicated staffing including physiotherapy open 24 x 7 x 365. Beds will operate at c. 90% occupancy. **Theatres** 2 new theatres: large, modular build with laminar flow and full lead lining forming part of a theatre suite with 2 anaesthetic rooms and 4 Stage 1 recovery beds together with co-located staff change, rest room and large storage area within the 'scrub zone'.

How does the proposal address the biggest demand & capacity gaps across the wider Region and within the system (by system/trust/specialty)?

- South Yorkshire & Bassetlaw ICS analysis has shown that the regions IP waiting list is 43% higher than in March 2020. There are 2,500 more patients waiting over 52 weeks and two thirds of them are in Orthopaedics.
- Orthopaedics also represents one of the largest gaps between planned IP/DC activity in 2022/23 and the target of 104% of 2019/20 activity, with the largest gap in patient numbers being at DBTH and Sheffield Teaching Hospitals.
- The scheme is one of two progressing in the area, which aim to significantly bridge the gap in orthopaedics inpatient and day case activity required to reduce the waiting list and meet changes in demand. (The other scheme is at Hallamshire Hospital and focusses on the Sheffield waiting list and includes HVLC orthopaedics and enhanced recovery).
- Locally, the admitted waiting list at the partner providers for the MEOC business case are as follows:

Trust	**Elective orthopaedic waiting list as at 24/11/2022**
Barnsley	1040
Rotherham	1200
Doncaster	3684
Total	**5924**

- The annual additional activity proposed in MEOC represents about 40% of the current waiting list and together with existing capacity, supports rapid reduction of longer waiters and the overall waiting list in line with Elective Recovery Plan targets. It will also support sustainable performance against expected levels of growth in the future.

ACTIVITY PROFILE – Additional activity delivered as a result of this investment

The activity profile is based on detailed work undertaken by the three partner trusts to identify the aggregate activity which meets the criteria for the MEOC HVLC profile. The activity profile will be reviewed annually and the ambition is to increase throughput within the same resources as the service and best practice is embedded and developed. Whilst the scheme does not have a direct impact on cancer activity it is expected that over time the released capacity at the host providers can address a broader range of specialities and pathways.

EXPECTED INCREMENTAL ACTIVITY			
	Elective - Cancer activity (000s)	**Elective – Non-Cancer activity (000s)**	**Outpatient FU activity (000s)**
H1 22/23	0	0	0
H2 22/23	0	0	0
H1 23/24	0	0	0
H2 23/24	0	953	1067
H1 24/25	0	1144	1290
H2 24/25	0	1144	1290
Recurrent Full Year Impact (25/26 onwards)	0	**2288**	**2579**

SECTION 3: PROJECT DELIVERY OVERVIEW

DELIVERABILITY ASSESSMENT

DELIVERY AND TIMETABLE

Please set out the anticipated commercial and procurement route, and provide a simple timeline with key milestones for the procurement and delivery of the scheme

Commercial and procurement route – scheme delivery
The project is currently being developed through the SBS Lot 3 Modular Healthcare for purchase framework directly with Module Co (SBS ref 10091) on the basis of developed relationship following a previous scheme at Doncaster Royal Infirmary and successful implementation at other surgical hubs nationally (e.g., Royal Devon and Exeter NHS Foundation Trust). Module Co are proposed to provide the full delivery route covering the Principal Contractor role for the modular and also traditional elements of construction.

The activities planned through to commencement of construction and to final commissioning are shown in the simple timetable below. Competition is not included in the timeline as the framework being utilised has already been tendered and allows for organisations to use a call off arrangement.

Activity	**Deadline**
Contract agreement	03/03/23
Contractor instructed to commence works	03/03/23
Planning permission granted	03/04/23
Enabling works complete	13/07/23
Off-site manufacture of modular theatres	13/07/23
Site installation of modular theatres commences	14/07/23
Internal refurbishment works commence	21/07/23
Handover of new facilities	09/10/23
Final commissioning	23/10/23

Clinical, operational and staffing model
Clinical and operational staff across the three partner trusts, working with local GIRFT leads for T&O and anaesthetics have agreed the main principles of the clinical, operating and staffing model for MEOC:

	1. Waiting lists and referral to MEOC managed by hosts based on criteria 2. Capacity would be allocated 50% to Doncaster & Bassetlaw and 25% each to Rotherham and Barnsley with annual review 3. GIRFT pathway in MEOC (and emerging best practice) 4. Post operative care provided by ACP with Anaesthetic support 5. No post operative surgical review unless by exception 6. Standardised pre-assessment and peri-operative care 7. Maximised standardisation of equipment and consumables 8. Surgeons follow their own patients OPD > MEOC > Follow Up 9. Profoundly ill patients transferred by ambulance to DRI 10. Data sharing (bloods, medical records, x-rays, etc) through existing ICS wide systems and access to DBTH systems as appropriate 11. Patient transport in extremis based on pre-assessment 12. Released capacity at host sites will be used to maintain current activity levels and ensure that MEOC activity is additive Refinement of these principles and the development of the operational, clinical and staffing models ready for implementation will take place during the 'fallow' construction period post business case approval. ***Workforce requirements (KLOEs)*** This business case includes the staffing required in the MEOC facility to deliver the workload identified above. The model of care principles agreed with clinicians and operational staff across the partner trusts incorporates all stages of the patient journey. Staffing for MEOC focusses on surgery and peri-operative care. The surgeons working in MEOC will rotate from their host organisations and costs will be reimbursed to allow backfill of capacity at host providers. The cost associated with anaesthetists for surgery and ward cover required is included but the decision as to whether anaesthetists will be employed by and dedicated to MEOC or rotate from their host organisations is not yet agreed. Costs do not include outpatient activity and pre-assessment taking place pre and post-surgery in the host trusts. ***Systems support for movement between organisations, recruitment, retention and rotational posts or job shares to support experience and workforce optimisation*** Trusts and partnership organisations in South Yorkshire (SY) have agreed a Workforce Sharing Agreement (WSA) to support the movement of staff across the system; this has been developed following engagement with trade unions and human resource representatives. A copy of the WSA can be provided upon request. In addition, all acute Trusts in South Yorkshire utilise the 'C19 digital staff passport' to speed up movement of staff between Trusts whilst ensuring the relevant safety checks are completed; it supports ad hoc or regular cover, temporary staff arrangements, post grad doctor moves etc. Staff can download the app and 'own their own credentials' if they are moving between sites/organisations and HR teams at all SY Trusts facilitate the process. The C19 passport is due to be replaced with the NHS DSP (digital staff passport) and DBTH, SCFT, STH and TRFT are currently engaged in beta testing of the latter product. GIRFT provides helpful benchmarking data with regards to service quality and performance, including pathway and workforce information. Workforce recruitment, retention and development is considered by the Orthopaedic Clinical Working Group, which reports through the Elective Collaborative Group and into the Diagnostic and Elective Oversight Group. Advice and guidance is available from the South Yorkshire Integrated Care Board (SY ICB) Workforce Hub, established in partnership with Health Education England (HEE) to support partner organisations across health and care to recruit, retain, and develop their workforce. A system-wide workforce planning exercise is underway. The SY Healthcare Science Council and SY Allied Health Professions Council meet monthly and can offer expert guidance with regards to the AHP and Healthcare Science elements of

	Orthopaedic pathways; the AHP Faculty also meets monthly to consider AHP workforce supply and development. Additional arrangements in place include: • Collaborative staff banks in place across medics (via Holt) and non-medics (NHSP) to mitigate reliance on agency • eRostering / eJob Planning group collaborating to enable best practice across Trusts in line with NHSE Levels of Attainment • Multi Year Modelling delivered across trusts to identify strategic workforce planning / supply requirements over next five years (professional group level) • Schools' engagement and careers team to encourage health and care roles across South Yorkshire Learning Environments and Placements (LEAP) programme across SY to support high quality clinical placements (non-medical) and unlock capacity barriers. • Apprenticeship lead in role to enable update of apprentices and levy sharing were appropriate • Employability programme underway to support widening inclusion across SY workforce • Health and wellbeing support across all staff via ICB workforce wellbeing Hub • Retention programme including focus on nursing and AHP preceptorships ***On-call and out of hours care*** On-call and out of hours care will be provided by nursing staff supported by Advanced Care Practitioners who will assess patients based on an agreed checklist. A duty anaesthetist will provide dedicated cover out of hours. Recruitment and training will commence as soon as the business case is approved. ***E-rostering and job planning*** E- rostering is fully in place within orthopaedics, with flexibility on shift patterns for staff. Job planning reflects the service model, and sufficient clinical sessions have been planned to cover 48 weeks of theatre lists per annum. Staffing for week end and out of hours has been factored into the staffing model. ***Plans for more predictable working patterns*** The MEOC surgical hub is for elective orthopaedic patients only and is on a 'cold site' preventing mixing of trauma and medical patients making service delivery predictable. Theatre templates will be used for scheduling to maximise knife to skin time including the overlapping of cases and staggering of admissions. Pathways of care are defined, standardising inputs such as therapy and x-rays and adopt the latest GIRFT guidance. Pre-assessment will take place at the host trusts and will be standardised to ensure that patients are not cancelled on the day for predictable reasons. Training will be provided for staff both within MEOC and along the care pathway to ensure consistency of practice. ***Enhanced knowledge and skills development*** Plans are being put in place for visits and virtual meetings with best practice sites across the UK including SWLEOC at Epsom Hospital and SWAOC at Royal Devon and Exeter Hospitals. These engagement sessions will allow surgeons, anaesthetists, nurses, therapists and theatre staff to 'shadow' their colleagues to support knowledge and skills development. • Standardised anaesthetics, consumables and implants will support expert knowledge and safe practice • Pathway training for staff to deliver primary hip and knee replacement standard pathways

- Ward nurses with enhanced training so that shifts will have appropriately skilled nurses
- Flow training for admissions and theatre staff to implement fast list turnaround with overlapping of cases
- Waiting list co-ordinators trained on templates for planning staggered admission times
- Pharmacists' development of pre-pack TTOs and responsive medicines management
- Peri-operative pathways using therapists to optimise timely safe discharge
- All staff working within the unit will be trained so it becomes a staff led problem solving environment, with continuous improvement and ownership

Innovation with regard to enhance roles and accelerated training will form a core part of the further engagement and involvement of the wider clinical and operational fraternity which is planned to take place once business case approval is achieved. This work will liaise with wider system developments and ensure link across with the Sheffield orthopaedic hub at the Hallamshire.

Staff well-being and morale

MEOC is dedicated to predictable working patterns and with the best possible pathways of care, and will enable orthopaedic trained staff to do their jobs well for the type of patients they are trained to care for. The service has been modelled to determine the right level of staff for each discipline to deliver the pathways, and to manage workload, enabling staff to work without stress and within their hours. There will be training opportunities and career progression into new and advanced roles. Career progression opportunities will be available to retain and ensure experience and knowledge.

The MEOC facility will have good staff facilities and be well equipped. The whole unit will be run as a single service, supporting development of a cohesive team thriving on excellent outcomes. The plans to further develop the MEOC facility beyond this proof-of-concept stage into a larger Centre of Excellence will provide staff with further opportunities and an exciting future.

Staffing Plans

The staffing required for MEOC has been developed and signed off by clinical leads in each of the respective areas across the three partner providers. Further more detailed discussions are planned to engage with and development staffing model plans with the workforce post approval of the business case.

The recruitment timetable is predicated on:

- The handover and opening date for the facility
- The need for senior staff to support commissioning activities
- The latest date staff must be available to:
    - Minimise costs in advance of live operation
    - Maximise the time available for recruitment
- The need for induction, orientation and training

Staff Type	Detail	WTE	Target Recruitment Date
Theatre staff	Band 6 Nurse	2.96	Aug-23
Theatre staff	Band 5 Scrub Nurse	2.96	Sep-23
Theatre staff	Band 5 ODP	2.96	Sep-23
Theatre staff	Band 2 HCA	2.96	Sep-23
Theatre staff	Band 1 / 2 Domestic	2.96	Sep-23
Theatre staff	Band 5 Recovery Nurse	2.80	Sep-23
Radiology	Band 7 Radiographer	1.20	Sep-23

Anaesthetics	Anaesthetist Consultant	3.00	Aug-23
Surgery medics	Surgical Consultant	1.67	Aug-23
Surgery medics	Surgical Assistant (SpR)	1.67	Aug-23
Ward nursing	Band 7 nurse	1.00	Aug-23
Ward nursing	Band 6 nurse	1.00	Sep-23
Ward nursing	Band 5 nurse	7.27	Sep-23
Ward nursing	HCA Band 2	6.79	Sep-23
Ward nursing	Ancillary housekeeper	0.50	Sep-23
Ward nursing	Ward clerk B3	1.10	Sep-23
Ward therapists	Band 6	2.00	Aug-23
Ward therapists	Band 4	3.00	Sep-23
Ward therapists	Band 3	1.50	Sep-23
Ward ACP rota	Advanced Care Practitioner B7	3.00	Aug-23
Other	Admin for booking B2	2.31	Oct-23
Total WTEs		**54.59**	

All staff currently supporting the orthopaedic elective pathways across the three trust partners will be offered the opportunity to transfer sites. This will need to be balanced with maintaining a safe services at the host sites through cross charging of costs to support backfill. All of these staff will come from within orthopaedics so there is no impact on other areas. During the 'fallow' construction period further work will be undertaken to determine the details around: movement between organisations, recruitment, retention and rotational
posts or job shares to support experience and workforce optimisation.

The table above shows the staff for recruitment, and planned appointment date. Harder to fill posts such as anaesthetics, ward and theatre staff will commence recruitment (where no recruitment scheme is already in place) as soon as the scheme is approved, and contingency plans will also be implemented.

Challenges affecting the implementation of the MEOC staffing model
Recruitment of the workforce for the MEOC facility is the most important challenge to be overcome. The key recruitment issues are:

- Anaesthetists (Very high risk)
- Theatre staff (High risk)
- Ward nursing support staff (Moderate risk)
- Radiographers (High risk)

Anaesthetists – Partner trusts are currently recruiting to anaesthetic posts and this has proved unsuccessful over the last year. Options to mitigate this problem include: Overseas recruitment, agency locums and waiting list initiatives (WLIs). Using agency or WLIs will impact on costs and therefore is not a preferred approach. This issue has been assessed through sensitivity analysis in the finance model.

Theatre staff - Rotherham has significant issues with sickness and vacancies in theatre staff and posts have proved hard to recruit to. Long term agency posts could mitigate the need for staff but at a higher cost.

Ward nursing support staff – Low pay associated with these roles make them unattractive. Potentially offering a strong route to Nursing Associate (B4) roles will help retain staff and for them to see a longer career trajectory, but it won't be easy to get stability and consistency in this area of the MEOC workforce

Recruitment programmes are in place locally and at ICS level to address these areas. The Sheffield surgical hub has identified the same issues and recognises the inability to recruit will have an impact on throughput. This will also be the case for MEOC.

RISKS TO DELIVERY

Please set out the potential risks to delivery and mitigating actions to address these.

The following table sets out the key risks and mitigations for MEOC:

Risk	Mitigation
Local and national shortage of certain professional groups for which recruitment is required to create a dedicated staffing model for MEOC.	Workforce action plan in development including: • Ambitious recruitment drive • Potential overseas recruitment • Promotion of the unit as a great place to work. • Alternatives where possible • Different models of care • Temporary use of agency and locums
If the MEOC staff are used to support the orthopaedic trauma service or wider Trust emergency pathway, the planned theatre throughput (activity) cannot be fully delivered	The Trusts including wider MSK to commit to ring fencing resources (beds, theatres and staffing). Location of MEOC on a 'cold site' away from emergency pathways will mitigate this issue.
Existing staffing may find it difficult and therefore be unwilling to move to the MEOC away from their existing base of work	The needs and issues of each staff group will be understood, and concerns addressed. This issue will be restricted to surgical (and potentially anaesthetic) staff as they will be the only peripatetic staff within MEOC.
The business case assumes that all activity in MEOC is additional and will be funded by the Elective Recovery Plan at 75% of tariff. This assumes that the underlying activity is delivering 104% of 2019/20 levels. This is currently not the case and there is a risk that by the time the unit opens revenue funding will not be available.	The partner organisations are undertaking a review of private work which could be repatriated to MEOC. Depending on the outcome of this review this work could offset or in the best case fully fund the workload in MEOC.
The business case assumes that patients will travel to MEOC for their surgery. There is a risk that a proportion choose to receive their surgery at their local hospital site.	The initial view is that the attractiveness of the MEOC facility with lower waiting times and a modern environment with good parking will result in patients choosing MEOC. It is envisaged that a public consultation may be required if patients are to be directed to MEOC. There is evidence that patients will travel to take advantage of shorter waiting times.
The location of the new facility results in harder to reach patients being excluded from the service and has consequent health inequality impacts.	It has been agreed that patients will be assessed for access to patient transport where this is a barrier to receiving care. This will be carried out at pre-assessment using criteria and the costs for patient transport are included in the financial costs for MEOC.
Slippage due to delays with construction and availability of materials	The contractual arrangements in place will ensure that provided approval for the business case is

		received during February 2023 the timelines to deliver the new building will achieve this by late October 2023. The approach to construction is off-site, modular build which offsets the timeline risk associated with traditional on-site build. There is a residual risk associated with the ground works which will be managed through the contract.
	Risk of inflation impacting on the capital costs taking them above the £15 million allocated to the scheme.	The arrangements with the main contractor include a cap on inflation through to the proposed business case approval in February 2023. Provided this timeline is met, the main capital costs associated with the modular build element, the largest proportion of the scheme, will not increase. There is a residual risk associated with inflation in relation to the non-modular works and also associated with delayed approval of the business case. Appropriate contingencies have been put within the financial numbers to offset this.
	Agreement has been reached in principle with clinical colleagues from across the three partner organisations with regard to the clinical, operating and staffing model. Due to time constraints, it is recognised that further, more detailed work will be undertaken to refine the assumptions which sit behind these principles. There is a risk that known challenges associated with the model of care are not agreed in a timely manner and in readiness for opening of MEOC.	A programme of meetings is currently underway with clinical colleagues to review the design of the MEOC building and further meetings have been discussed with regard to visits to best practice sites to align views on key operating arrangements. Further meetings will be put in place during the fallow, construction phase to engage with clinical colleagues more broadly and translate the principles agreed into the detail required for operational readiness.
	Planning permission has not yet been granted and resource constraints at Doncaster Metropolitan Borough Council (DMBC) have delayed progress. There is a risk that planning permission will not be granted or more likely that conditions will be placed on permission which may or may not add cost to the scheme.	DBTH has a very strong relationship with DMBC and as set out in the “Planning Assumptions" section the scheme impact from a planning perspective is limited. A timetable has been agreed for the delivery of permission and dialogue is ongoing with planners to ensure that this risk does not accrue.
PLANNING ASSUMPTIONS Please set out the current planning position, and the steps that will be taken to ensure appropriate planning permission is in place.	**Approach** The Development Control Plan and proposals for MEOC have been submitted to the local authority for pre-application advice. An initial submission was made on 31/08/2022, followed by a second submission with additional/revised information on 18/10/2022 **Feedback** Due to current workload pressures at the local authority, we are yet to receive formal feedback on the proposals. The Trust maintains a good working relationship	

	with the planners and is in frequent dialogue to discuss the long-term implementation of the site development plan at Mexborough Hospital. **Scheme impact** In planning terms, the scheme will have minimal impact on the hospital site: • No net loss of parking on site • Building height is comparable with adjacent buildings • No visual or acoustic impact on adjacent residential property **Resolutions** The design team will continue constructive discussions with the local authority to assist the timely completion of the application process. Full planning approval is anticipated in Spring 2023.
PROVIDER CAPACITY AND CAPABILITY Please provide a brief overview of the experience of the SRO and Exec Team accountable for the project.	The SRO and executive team have delivered previous schemes of a similar scale in recent years. There is an existing governance structure, supported by Trust executives who also have an history of successfully delivering schemes. The scheme has full backing and engagement of the clinical teams who are committed to the solution for orthopaedic patients. A dedicated programme manager is leading on this project and clinical leadership resources time is also built into the delivery. SY ICS has resources and programmes of activity in place to support the development of the orthopaedic hubs proposed and will continue to be closely engaged with the project through development and delivery strengthening provider leadership.

SECTION 4: FINANCIAL OVERVIEW
These Tables can be provided in Excel Form. If a proposal involves multiple Providers, these Tables will need to be completed for each individual Provider.

FUNDING SOURCES

PLEASE SET OUT ALL FUNDING SOURCES FOR THE PROJECT	DHSC PDC £	14,921,104
	Other (please specify) £	0
	Total £	**14,921,104**

CAPITAL EXPENDITURE PROFILE

FUNDING SOURCE	2022/23 Q1 £'000	2022/23 Q2 £'000	2022/23 Q3 £'000	2022/23 Q4 £'000	2022/23 Total £'000	2023/24 Total £'000	2024/25 Total £'000	TOTAL £'000
DHSC PDC funded capital expenditure			420	1,348	1,767	13,153	0	**14,921**
Other *(specify)*	0	0	0	0	0	0	0	**0**
Total			**420**	**1,348**	**1,767**	**13,153**	**0**	**14,921**

BREAKDOWN OF SCHEME CAPITAL COST (using OB Form headings)

FUNDING SOURCE	2022/23 Q1 £'000	2022/23 Q2 £'000	2022/23 Q3 £'000	2022/23 Q4 £'000	2022/23 Total £'000	2023/24 Total £'000	2024/25 Total £'000	TOTAL £'000
Works Costs	0.0	0.0	179.1	716.3	895.4	6,490.1	0.0	7,385.5
Fees	0.0	0.0	71.6	60.8	132.4	101.4	0.0	233.8
Non-Works Costs	0.0	0.0	0.0	0.0	0.0	121.4	0.0	121.4
Equipment Costs	0.0	0.0	0.0	0.0	0.0	786.8	0.0	786.8
Optimism bias	0.0	0.0	23.9	74.1	98.0	715.3	0.0	813.3
Planning contingency	0.0	0.0	22.5	69.8	92.3	673.2	0.0	765.5
Inflation Adjustment	0.0	0.0	70.1	217.4	287.5	2,097.6	0.0	2,385.1
VAT	0.0	0.0	52.5	209.8	262.3	2,167.5	0.0	2,429.8
Total	**0.0**	**0.0**	**419.7**	**1,348.2**	**1,767.9**	**13,153.3**	**0.0**	**14,921.1**

Please provide a narrative on the basis of the costs e.g. tendered costs, PUBSEC indices, cost advisor reports. Please **STATE** the following:

1) PUBSEC Indices used:	Extension of PUBSEC Tender Price Index of Public Sector Building Non-Housing
2) Basis of the costs: HPCG / benchmark rates from cost advisor / tendered costs / schedules of rates / previously tendered rates.	Costs are based on the P+HS drawing DBHOH-PHS-XX-XX-DR-A-020_P02 Internal Works, dated 19.10.2022. The Modular Theatres cost is based on a fixed price quotation provided by ModuleCo Ltd, which is inclusive of a design and build risk, that ModuleCo have offered to fix the price

	of the two modular theatres until February 2023 when it is expected an order can be placed for construction.
3) Cost advisor Review of the vfm / procurement process.	The fixed price offer has been reviewed by WT and is considered to offer value for money for the scope and specification proposed in the current market and that they represent value for money. The following embedded document is the cost advisor report:  MEOC Modular Theatres VFM Statem

STATEMENT OF COMPREHENSIVE NET INCOME **Incremental Impact of Scheme on the I&E of Lead Organisation**					
	2022/23 £'000	**2023/24 £'000**	**2024/25 £'000**	**2025/26 – 2031/32 £'000**	**Total £'000**
Operating income from patient care activities	0	3,089	7,500	71,505	82,094
Other operating income	0	752	871	0	1,622
(Employee expenses)	0	(1,424)	(2,908)	(22,140)	(26,472)
(Operating expenses excluding employee expenses)	0	(8,850)	(5,089)	(38,113)	(52,052)
Less Cash Releasing Benefits	0	0	0	0	0
Operating surplus / (deficit)	**0**	**(6,433)**	**374**	**11,252**	**5,192**
Finance Income	0	0	0	0	0
(Finance Expense)	0	0	0	0	0
(PDC Dividends Payable)	0	(180)	(300)	(3,225)	(3,705)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	0	0	0	0
Gains / (Losses) on transfers by absorption	0	0	0	0	0
Retained surplus / (deficit)	**0**	**(6,613)**	**74**	**8,027**	**1,487**
Adjustments (including PPA, IFRIC 12 adjustment, and impairments)	**0**	**6,814**	**0**	**0**	**6,814**
Adjusted financial performance retained surplus / (deficit)	**0**	**201**	**74**	**8,027**	**8,301**

STATEMENT OF COMPREHENSIVE NET INCOME Whole Trust Position including the Investment over the Appraisal Period					
	2022/23 £m	**2023/24 £m**	**2024/25 £m**	**2025/26 – 2031/32 £m**	**Total £m**
Operating income from patient care activities	451.2	439.3	437.0	3,837.4	5,164.8
Other operating income	50.9	55.9	56.2	459.6	622.5
(Employee expenses)	(327.0)	(317.3)	(337.4)	(3,056.8)	(4,038.6)
(Operating expenses excluding employee expenses)	(185.0)	(180.2)	(181.8)	(1,197.4)	(1,744.4)
Less Cash Releasing Benefits	**0**	**0**	**0**	**0**	**0**
Operating surplus / (deficit)	**(9.9)**	**(2.3)**	**(26.0)**	**42.8**	**4.3**
Finance Income	0	0	0	(0.1)	0
(Finance Expense)	(0.3)	(0.3)	(0.2)	(1.3)	(2.1)
(PDC Dividends Payable)	(6.0)	(7.3)	(7.4)	(75.6)	(96.3)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	0	0	0	0
Gains / (Losses) on transfers by absorption	0	0	0	0	0
Retained surplus / (deficit)	**(16.2)**	**(9.9)**	**(33.6)**	**(34.2)**	**(94.1)**
Adjustments (including PPA, IFRIC 12 adjustment and impairments)	30.2	15.1	20.0	111.2	176.4
Adjusted financial performance retained surplus / (deficit)	**14.0**	**5.2**	**(13.6)**	**77.0**	**82.3**

SECTION 5: FIVE CASE MODEL PROJECT DETAIL	
STRATEGIC CASE	
a) Please set out the strategic rationale and case for change.	***Strategic Rationale*** The 'Elective recovery planning supporting guidance', April 2022, sets out a clear strategic context for the NHS. *"The pandemic has placed considerable strain on planned service delivery, which was already under pressure before the pandemic. Consequently, there are now significant waiting lists across the country and potentially more patients still to come forward. Our plans will need us to do things differently, creating additional capacity and changing for the better the way services are delivered, while giving patients more control over their experience in the NHS."* It describes a delivery plan and the key ambition, to which MEOC responds, relating to the reduction of waiting lists: "Eliminating the longest waits of over two years, except when it is the patient's choice, by July 2022. Following this, the ambition is to eliminate waits of over 18 months by April 2023 and waits of over one year by March 2025, except where patients choose to wait longer or in specific specialties". Orthopaedics is the largest component of the waiting list for South Yorkshire ICS making up approximately 60% of the total. MEOC will play a key role in the South Yorkshire ICS in delivering required improvements by March 2025, specifically in relation to orthopaedic waiting lists. To achieve the required waiting list reductions the volume of activity required at a national level is an increase of 30% over 2019/20 levels. GIRFT provides guidance on best practice pathways and expected standards of performance. Developing local approaches to address shortfalls against GIRFT standards is an important strategic driver for this project. ***The case for change*** The South Yorkshire ICS will not be able to achieve the future plans for elective recovery without intervention. There is insufficient inpatient capacity for the volume of orthopaedic patients needing treatment. Trusts have made very limited progress in ring fencing orthopaedic infrastructure on their acute sites, and cannot guarantee patients uninterrupted admission to elective surgery. Orthopaedic staffed beds often underpin medical capacity to the detriment of elective patients. Additionally, there is insufficient theatre capacity to meet the required demand. Rises in trauma workload often result in cancelled lists and de-prioritisation of elective cases. The lack of dedicated elective orthopaedic facilities inhibits the development of best practice pathways and frustrate productivity and efficiency initiatives. There are gaps in the staffing required to deliver the intensity of workload required and disruption to the consistent running of elective orthopaedic services adds pressure and impacts detrimentally on staff and patient experience. Acute site provision of elective orthopaedics often results in sharing arrangements for equipment again prevents smooth running of the service.
b) Please explain how this scheme will contribute to the delivery of the programme aims.	MEOC will contribute to the broader programme aims through: 1. Creating an environment which delivers increased activity at greater levels of productivity and efficiency 2. Enabling an orthopaedic elective model and pathways delivered to the patient using best practice methods 3. Providing a facility that is specifically designed and fit for purpose, maximising access and flow, reducing waste and delays on a 'cold site':

	a. All facilities are co-located together – admission, discharge, theatres, recovery, theatre support and staff amenity space, and beds b. Enabling full MDT working to support the entire pathway c. Efficiently and effectively linking together pre-admission and post discharge services across the partner trusts d. Exploiting systemwide digital functionality to ensure patient information is available where it is needed 4. It will remove the service from the disruptions of the emergency pathways at the acute sites 5. It will allow greater management control of the service because the resources are dedicated, and ring fenced for orthopaedics 6. It will improve the patient experience and outcome with a predictable/controlled environment 7. It will be a better place for staff to work, where they can do their jobs well 8. Provides greater assurance that waiting times can be reduced and the national targets will be met Specifically, MEOC will deliver additional activity over and above existing volumes to support elective recovery programme aims. Orthopaedic elective provider spells across BH, TRH and DBTH were 11,881 in 2019/20 (Source: HED). MEOC will deliver 2,288 spells initially, making a 20% contribution to increases in volumes of activity over 2019/20 with ambitions to improve throughput by increasing day case rates and theatre productivity in future years. MEOC is not designed to specifically impact on cancer pathways. However, it will release capacity at host organisations and discussions have been held with regard to the potential to re-purpose this for cancer work, increasing capacity in this area.
c) Provide confirmation of stakeholders e.g. support from clinicians, commissioners, cancer alliances and STP / ICS accountable officers (formal letters of support to be appended to this business case template).	The MEOC business case is fully supported by representatives from across the three provider trusts: Barnsley Hospital, The Rotherham Hospital, and Doncaster & Bassetlaw Teaching Hospitals. The following groups have been engaged in the detail development of the business case: • Executive directors • Clinical stakeholders • Operational stakeholders In particular, clinical stakeholders from each of the trusts have recently attended three business case development meetings focusing on clinical, operational and staffing model development. Through these meetings the leads for Trauma & Orthopaedics confirmed their support for the project. All the meetings have been attended by South Yorkshire ICS representatives of the Elective Recovery Programme and who are strongly supportive of the scheme. As the host trust, DBTH has provided regular reports to its Trust Executive Group and Finance and Performance Committee. Formal letters of support are included in Appendix 6.
d) Please outline the investment objectives for the project.	The investment objectives for the MEOC project are as follows: 1. To develop a high-volume, low complexity elective orthopaedic service on a non-acute site 2. To create sufficient capacity to deliver material improvements to the orthopaedic waiting list 3. To configure the solution to support dedicated staffing, beds and theatres free from interruption due to medical and trauma outlier patients and the demands of broader emergency services

	4. To ensure that the location of the facility supports equitable access for patients across the catchments for the three partner trusts 5. To provide an environment which supports high quality care and a positive patient and staff experience 6. To deliver improved productivity through better theatre utilisation and increased delivery of day case lower limb arthroplasty 7. To design a clinical and operational model which is consistent with GIRFT and emerging best practice achieving high levels of performance safely 8. To create opportunities for career progression through innovative new roles supported by training and education 9. To adopt and develop digital and IT solutions to support service delivery and ensure information is provided seamlessly between provider organisations to support safe and effective care 10. To work in partnership with local providers and across the South Yorkshire ICS to develop a new collaborative model which will act as a proof of concept for future initiatives 11. To ensure that the solution delivered is sustainably affordable and value for money
e) Please confirm fit with estate strategy.	**Fit with Estates Strategy** The new MEOC facility, highlighted in blue in the diagram below, forms part of the development control plan for the Montagu Hospital Mexborough.  ***Development Control Plan*** The embedded document below provides a diagram of the Mexborough Hospital. It identifies the MEOC project together with the other initiatives which are planned for the site. MEOC-PHS-XX-XX-D R-A-002_Site Develop The Development Control Plan (DCP) for Montagu Hospital incorporates a number of schemes to be developed, including MEOC, MEOC expansion, Hydrotherapy, Diagnostics (CDC), and new electrical infrastructure. The DCP has been developed over several iterations as site analysis has informed the design process and individual elements of the scheme were explored in detail with clinical stakeholders.

The premise of the DCP is to co-locate key functions in the centre of the hospital site, improving internal staff/patient links and allowing efficient distribution of services. The initial phases of development are positioned to utilise immediately available areas of the hospital site. Later phases will then reconfigure the internal access roads around the new buildings, freeing up space for expansion of the new facilities.

Within the DCP, this project focuses on the modular MEOC Theatres, plus refurbishment of existing bedrooms.

Explanation of location selected (key criteria)

The DPC submitted for approval provides key benefits for the hospital, including:

- Consolidation of all new development in one central location, providing opportunities for reduced infrastructure costs
- Re-use of existing, underutilised site (e.g. Mortuary)
- Development is in a strategic position, with close proximity to all existing buildings, entrances / exits and car parking areas
- MEOC can be delivered immediately utilising off-site construction solutions developed to date
- Future expansion of Theatres and Beds is possible within the masterplan
- Hydrotherapy can be independently procured and delivered without affecting existing road infrastructure / MEOC / Diagnostics building
- Expansion to MEOC can be delivered in phases (if required) with potential to collocate additional Beds and Theatres
- Location of proposed new buildings limits the potential conflict with existing road infrastructure whilst retaining daylight to all building elevations
- New road layout allows for a more compact arrangement of buildings with greater space for MEOC expansion

Dependencies and Constraints
The Development Control Plan seeks to minimise interdependencies, and as a result there is no direct connection between and any of Hydrotherapy, Diagnostics or Electrical Infrastructure.

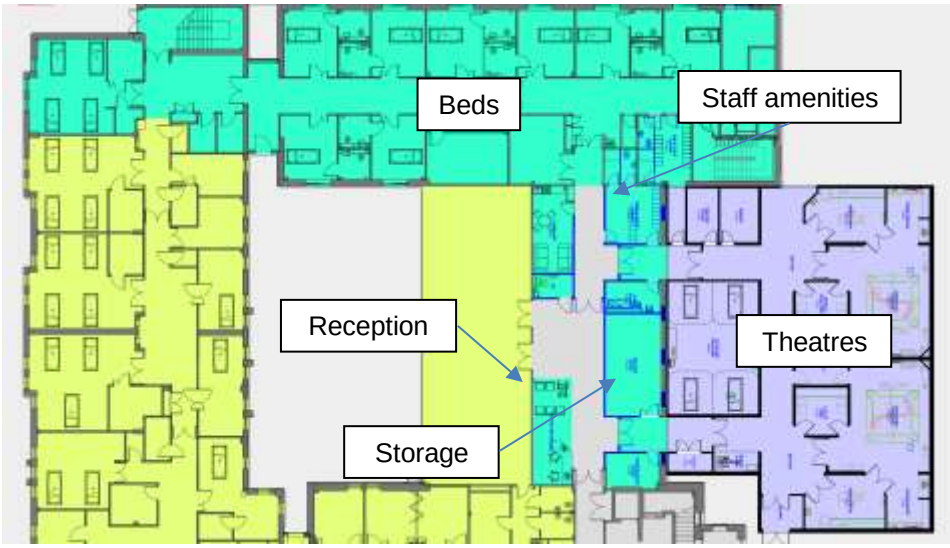
Some dependencies to still remain:

- Expansion of MEOC (potentially a third operating theatre and additional beds) connects into the current proposed scheme, and is thus dependent on its completion
- Hydrotherapy is dependent on completion of electrical infrastructure works in order to support the therapy pool

Power
The current sites facilities and activities are nearing the site's agreed electrical allowance with the National Power Grid. The additional theatres and ancillary rooms will add further demand on the current electrical infrastructure.

Discussions with the National Power Grid has identified that the sites current HV transformer settings can be increased to its maximum capacity 800KvA, this will allow sufficient power to power the new facility. To enable the increase in power, the sites LV infrastructure will need to be reconfigured by introducing a new LV distribution panel. This design is nearing completion ready for an order to be placed and the works to commence.

Design of Preferred Option



The following embedded document provides a detailed drawing of the proposed MEOC facility:

Montagu Hospital MEOC 161122 (1).pdf

Description of key features

MEOC involves the provision of two new modular operating theatre suites adjacent to the existing Rehab block, sharing access but with dedicated reception. The link to the main hospital will be improved to provide a more direct route, incorporating a new platform lift to deal with the level change.

MEOC Theatre Suite

The Theatre Suite consists of two main elements – a new modular building containing two operating theatres and supporting facilities, and conversion of existing space in the Rehab building to provide reception, staff facilities, and storage.

The modular section is designed to be mainly constructed and fitted out in the factory, to the highest standards, based on hundreds of previous successful projects. This achieves the highest quality in the shortest time, with minimum disturbance and pollution. Theatres are lead lined and laminar flow.

The room sizes generally conform to the recommendations of HBN26, and provide spacious, carefully planned spaces, based on previous solutions which have been highly recommended by users.
Access is via an improved internal route using a new platform lift to the main hospital, or directly into the adjacent dedicated 12 bed inpatient ward. This provides safe internal progressive horizontal escape solutions, with an external access providing fire brigade access and a last resort escape option.
Each Theatre has its dedicated anaesthetic room, sterile pack prep, and scrub recess, with a shared dirty utility. A four bay 1st Stage Recovery room is adjacent.

The converted area includes staff change facilities with through access directly into the theatre corridor, a staff rest room, cleaners room, reception/ waiting area, and storage areas totalling 45sqm.

14 existing bedspaces will be refurbished and reassigned to create 12 beds dedicated for orthopaedic elective patients, and further internal works will create

new staff change and storage areas. Release of the existing 14 beds is required by July 2023 to allow works to commence. Service leads have agreed the release of these beds which are largely used for escalation and winter pressures.

The remaining areas are retained for Rehab use.

Future phases could include an extension to the MEOC project, hydrotherapy pool, and diagnostic unit, supported by a revised layout, extended car parking, and infrastructure development.

The final result will create a coordinated and efficient centralised facility.

Functional content

The proposal is designed to create effective elective surgery facilities to meet the urgent demand.

The new operating theatres are designed to the latest standards, and built and fitted to the highest quality using factory-based Modern Methods of Construction.

The supporting wards will include 8 single rooms and one 4 bed ward with ensuite facilities, ideal for the varying requirements.

Schedules of Accommodation
The following embedded document sets out the schedule of accommodation for MEOC.

3587-PHS-XX-XX-L-A
-0001 P02 Schedule o

Compliance with HTM / HBN
Generally the scheme will be designed, installed and commissioning in accordance with the relevant HTMs and HBNs. Due to the site location, available footprint and part refurbishment on the scheme there will be minor derogations which will be reviewed as part of the design development process and either addressed and designed out as necessary or accepted and included in the final derogation schedule.

Refurbished areas utilise existing room sizes and bed spacing. These existing areas are below the recommended areas in HBN 00-03 but review of the activity zones confirms that the proposed room layouts are functional and meet IPC requirements for patient spacing.

2D Layouts
The following embedded document sets out the two-dimensional layout for the scheme:

Montagu Hospital
MEOC 161122 (1).pdf

3D Massing
The following embedded document illustrates the three-dimensional massing of the MEOC scheme:

Montagu Hospital
View 1 111122 (1).pdf

Montagu Hospital
View 2 111122.pdf

Equipment

All required fixed equipment will be provided by the modular supplier. The capital costs include a budget for moveable equipment and clinical meetings are being held to finalise the specific list in December 2022 and January 2023. The main items of equipment assumed for each theatre include:

• Operating table	• Patient Trolleys
• Imaging equipment	• Stack system
• Infusion pumps	• Defibrillator
• Patient monitoring equipment	• Suction carousel
• Mindray monitors	• Diathermy machine
• Instrument trolleys	• IT equipment
• PACS Screen	• JAX's trolley
• PC's	• Mobile trolleys
• Telephones	

Net Zero Carbon

The overarching design approach to the new Elective Orthopaedic Centre (OEC) building at Mexborough Montagu Hospital will be in line with the guidance principles set out by the NHS England Guidance Document "Delivering a Net Zero National Health Service". This will ensure the OEC building will have reduced energy and reduce carbon. The building will be designed with enhanced levels of insulation and high efficiency heating, ventilation and air conditioning plant. There is likely potential for the use of electrically driven high efficiency air sourced heat pumps that would provide the heating and hot water to the new OEC building. It would not be the intent to connect the building into the existing gas fired heating network. The scheme will also have high efficiency LED lighting within every space. A review of on-site renewable technologies will be carried out a detailed design stage consider technologies such as Photovoltaic panels to generate on site electricity that would feed back into the building.

Module Co as proposed provider have completed an in-depth carbon reduction plan written in accordance with ISO14064 and verified by BSI. As standard, MMC offers a more sustainable solution by reducing construction waste (ModuleCo recycle 90+% of all site waste produced) and providing a relocatable building with a 60-year structural design life. The facilities themselves are built from steel with at least 25% recycled content and that is completely recyclable at the end of use. The facility will be built to the latest Part L guidelines with Net Zero technologies incorporated, including Air Source Heat Pumps, to ensure the best operational sustainability. The above measures ensure a facility with low embodied carbon (compared to traditional construction) and high operational efficiency with efficient heating generation supporting the Trust Green Plan and the NHS with Net Zero 2030 goals.

Modern Methods of Construction

The new build element of the project will utilise in its entirety MMC, in particular Category 1 MMC, which will be pre-manufactured 3D primary structural systems with volumetric modules being 90% completed off-site and delivered to site onto pre-prepared foundations.

This approach maximises the use of MMC to the very full potential and this element will have a pre-manufactured value (PMV) in excess of 90%.

There will be limited opportunity to use MMC in the refurbishment element of the project as the scope is relatively minor in terms of extend of work and mainly focuses on forming a few new internal rooms, decorations and amendments to the existing M&E services.

Access and parking

Access into the proposed area is typically through the existing hospital. The existing level differences within the hospital ground floor are currently addressed

	via a ramp; this scheme proposes a new lift to bridge the level difference and provide a more direct route to MEOC. The proposed location for the theatre extension covers a number of existing parking spaces. This provision will be re-provided immediately adjacent to the Theatres to ensure there is no net loss of parking. ***Patient and staff flow in building*** Movement within the department has been considered as part of the overall layout. As noted above, a new lift provides a direct and accessible route for patients arriving from the main hospital into Block 15. Patients arriving from the site car parks can utilise the existing entrance ramp and doors, which arrive at the same point, overseen by the Block 15 reception area. From here, patients can enter the Theatre block, the circulation is designed to provide a separate entrance/exit for patients pre-/post-surgery. The staff change is also designed as a pass-through area with an access either side of the clean corridor extent. ***Digital capabilities*** The MEOC costs include provision for the peripheral devices required in the facility. DBTH is procuring and implementing a new cloud based EPR system which will support controlled access to digital capabilities required to enable the MEOC model of care across partner organisations. SY ICS has in place and is developing further initiatives to provide connectivity between system organisations, for example: ICE Open Net already provides blood results from all SY Trusts to other SY Trusts. Appendix 7 sets out our response to the Digital Capability KLOEs. ***Flexibility and expansion options*** Designs have been mindful of the potential need to expand theatre and bed capacity for MEOC if the ambition to pursue a larger Centre of Excellence is pursued. Various drawings have been prepared which identify alternative locations for additional theatres and beds colocated with the proposed scheme.
ECONOMIC CASE	
a) Please submit a VFM template with this business case template.	The net present value of costs and benefits assessed demonstrate a value for money ratio of 1.3. This indicates that the scheme is value for money over the 10 year assessment period included in the VFM model.

Incremental costs and benefits	10 year VFM: Present Value of Cashflows
COSTS	
Capital Costs (including optimism bias)	11,547,049
Revenue Costs	41,341,845
Transitional & non-recurrent revenue costs	-
INCREMENTAL COSTS TOTAL	**52,888,894**
BENEFITS	
Capital Costs (including optimism bias)	3,502,097
Revenue Costs	-
Transitional & non-recurrent revenue costs	-
Cash Releasing Benefits	64,558,438

	Non-cash Releasing Benefits | -
	INCREMENTAL BENEFITS TOTAL | **68,060,536**
	Value for Money Ratio | **1.3**

The VFM template is embedded here: VFM template MEOC V4 11-12-22.xlsx

b) Please provide an incremental VFM analysis that shows the VFM ratio (Net Present Social Value) for Business As Usual and the preferred option and provide an explanatory narrative on the VFM analysis.	There is no Business As Usual option. This is consistent with other schemes where new investment is made to deliver new activity. As a consequence, there are no comparative benefits, risks and costs analysis for this scheme and no VFM ratio.
c) Provide a narrative on: - The options considered to achieve the scheme's objectives, including business as usual. - The process through which the long-list of options was narrowed down to the preferred option. - The main costs, benefits and risks for the Business As Usual and preferred option. - The appraisal period for the scheme.	The options appraisal for identification of MEOC as the preferred way forward was undertaken at regional, system and local levels in response to the strategic imperative to reduce elective waiting times. Initial work was undertaken to identify the focus for investment at a South Yorkshire system level. This identified the key specialties and other enabling areas which would benefit through investment. Analysis by Newton as part of the national programme of developing the elective recovery plan confirm that Orthopaedics presented the best opportunity for delivery of improved waiting times. Agreement was reached that the system will be best served through the development of two hubs, one serving Sheffield and the other supporting Barnsley, Rotherham and Doncaster & Bassetlaw patient populations. MEOC is a response for Barnsley, Rotherham and Doncaster & Bassetlaw and was identified as Mexborough Hospital represents the only potential cold site solution, an essential criterion for separation of elective pathways from acute and emergency pathways. South Yorkshire ICS included the MEOC proposal in its consolidated long list of options for consideration by NHS EI North East & Yorkshire and the NHS EI central team. As a result of this exercise both MEOC at Mexborough Hospital and the surgical hub at the Hallamshire Hospital were allocated funding subject to a business case process. Options were then considered for the potential to deliver a solution at Mexborough Hospital: **Option Name** | **Option Description** **Long-List** **Option 2 (BAU)** | 10 Bed Refub + 1 x Existing Theatre Refurb **Option 3** | 2 Theatres + Refurb of Ground Floor Wards for surgical beds **Option 4** | 2 Theatres + 12 new Beds + Refurb of First Floor Wards for surgical beds **Option 5** | 2 Theatres + 24 new Beds **Option 6** | 2 Theatres + Refurb of Ground Floor Wards for surgical beds + Alterations to Rockingham admissions / discharge **Option 7** | 2 Theatres + 12 New Beds + Alterations to Rockingham admissions / discharge **Option 8** | 2 Theatres + 24 New Beds at Ground Floor + Alterations to Rockingham admissions / discharge **Short-List** **Option 3A** | 2 Theatres + Refurb of Ground Floor Wards for surgical beds + lift **Option 4A** | 1 Theatre + 10 new beds + Refurb of Ground Floor Wards for surgical beds + lift **Option 5A** | 2 Theatres + 26 new Beds Each of the options was costed and reviewed from an affordability and estates feasibility perspective together with the potential impact on other existing services. Option 3A was the only option that could be afforded within the budget of £15 million and deliverable without significant disruption to existing services. There is no Business As Usual option. This is consistent with other schemes where new investment is made to deliver new activity. As a consequence, there is no comparative benefits, risks and costs analysis for this scheme.

d) Confirm inflation, VAT, depreciation, PDC are excluded from the economic analysis.	Inflation, VAT, depreciation, PDC have been excluded from the economic analysis.
COMMERCIAL CASE	
a) Please set out the commercial and procurement route, e.g. P22.	The project is currently being developed through the SBS Lot 3 Modular Healthcare for purchase framework directly with Module Co (SBS ref 10091) on the basis of developed relationship following a previous scheme at Doncaster Royal Infirmary. Module Co are proposed to provide the full delivery route covering the Principle Contractor role for the modular and also traditional elements.
b) Set out the basis of the negotiated position, including the final price for the works.	The modular element will be priced on the basis of a fixed fee using the NEC4 contract and GMP (as per P23) with risk managed through a 50/50 gain share but providing surety to the Trust in terms of maximum price.
c) Confirm status of any legal documentation or processes required for the scheme to be delivered in full and what (if anything) remains to be agreed.	The scheme as noted above will be delivered through Trust terms and conditions but also controlled by the NEC4 Contract signed by both parties and monitored by the Trust appointed Project QS (PQS)
d) We assume that Modern Methods of Construction (MMC) will be used for new builds. Please provide details of how MMC will be utilised.	The main element of the project (Theatres and recovery) is proposed to be delivered using an offsite modular construction approach which will initially provide a much shorter delivery timeframe on site compared to traditional methods, potentially shortening the time period to delivery and enabling earlier clinical activity. An offsite approach also minimises disruption by limiting time on site ensuring continued access for patients and healthcare professionals. The modules will be designed in close collaboration with the Trust, considering day-to-day challenges to create a space that would respond to prevailing challenges.
e) Confirm contribution to carbon reduction plan (if applicable).	Module Co have completed an in-depth carbon reduction plan written in accordance with ISO14064 and verified by BSI. As standard, MMC offers a more sustainable solution by reducing construction waste (ModuleCo recycle 90+% of all site waste produced) and providing a relocatable building with a 60-year structural design life. The facilities themselves are built from steel with at least 25% recycled content and that is completely recyclable at the end of use. The facility will be built to the latest Part L guidelines with Net Zero technologies incorporated, including Air Source Heat Pumps, to ensure the best operational sustainability. The above measures ensure a facility with low embodied carbon (compared to traditional construction) and high operational efficiency with efficient heating generation supporting the Trust Green Plan and the NHS with Net Zero 2030 goals.
FINANCIAL CASE	
a) Please provide narrative to support the detail provided in Section 4 (above).	**Capital Costing** ***Methodology*** The preferred option has been computed using advice from a modular contractor incorporated into an elemental cost plan. ***Basis of costs*** Costs are based on the P+HS drawing DBHOH-PHS-XX-XX-DR-A-020_P02 Internal Works, dated 19.10.2022. The Modular Theatres cost is based on a fixed price quotation provided by ModuleCo Ltd, which is inclusive of a design and build risk. ModuleCo have fixed the price of the two modular theatres until February 2023 when it is expected an order can be placed for construction.

Cost plan
A RIBA Stage 1 cost plan has been produced by WT Partnership, dated 01.11.2022. The cost plan totals £14,921,104, and includes: building works, associated main contractor design & build costs/fees, trust costs for equipment, fees, contingency/risk, and non-works costs, and VAT @ 20%.

OB forms
The cost plan that has been factored into OB forms for reporting purposes. Inflation has been calculated to mid point and all figures within the OB forms are directly taken from the elemental cost plan and adjusted for price level

Contingency and risk implications
Within the cost plan for the preferred option, planning contingency and optimism bias have been included as prescribed by NHS EI at 10% and 20% respectively of the build cost for the non-modular enabling/refurbishment works.

Due to the fixed price offer provided by ModuleCo Ltd, a combined percentage of 5% has been allowed for the Modular element of works only, as this is deemed a lower risk than the non-modular portion of works.

The percentages included in the OB forms are compounded percentages using the total risk allocations across the whole project (ie the figure is as the cost plan – the percentages are worked back from those actual allowances).

Cashflows
The cashflow has been produced including the necessary spend for the modular contractor to maintain a March project mobilisation and a May commencement of construction with all works (modular and refurbishment) will be completed within 2023/24 fiscal year.

Revenue Assumptions

The key revenue assumptions used in the financial model are as follows:

1. Income has been calculated on the basis of November 2022 HRG prices for the specific HRG's included within the inpatient work. Day case prices have been calculated based on the average price for the relevant HRG's relating to lower complexity upper limb, shoulders, hands, wrists, feet and ankles. HRG prices have been inflated for the Market Forces Factor for DBTH. For the period associated with the Elective Recovery Programme, through to March 2025, HRG prices are at 75% of tariff. Beyond this point, full tariff is assumed.
2. Capital charge funding has been assumed on the basis of the allocations provided for the period through to March 2025. After this point, the cost of capital is funded through the full tariff price (as described above).
3. Staff costs have been calculated based on the midpoint of scale. For anaesthetist and surgeon costs an hourly rate has been calculated and the total costs are based on the total hours agreed to meet the service requirements multiplied by the hourly rate.
4. Theatre consumables, prostheses, drugs and blood have been calculated using the latest, 2022/23, PLICS data for DBTH and are based on a combination of the number of spells and the number of lists per annum.
5. Overhead costs have been calculated using the latest, 2022/23, PLICS data based on an initial overhead absorption approach followed by a line by line review to ensure that all overhead costs allocated are relevant and appropriate. Overheads equate to 15% of total costs.
6. Capital charges have been calculated based on the total cost of capital included in the OB forms after an impairment of 50% to reflect the impact of inflation and other factors which affect the accounting valuation.

	7. PDC dividend has been calculated at 3.5% on the average net relevant assets for each year based on the incremental impact of the MEOC project on the trust's balance sheet. 8. Depreciation has been calculated based on the manufacturers estimate of the life associated with the modular buildings at 60 years and equipment has been depreciated over 10 years. 9. Revenue life-cycle costs are included within the overhead costs described above. Capital life-cycle costs are minimal during the first 10 years and will be picked up by the trust's capital programme. 10. The financial model does not include any productivity gains or cost improvements. It is likely that once the service in beds a higher throughput of day case work will be achievable with low variable costs. 11. Costs and income included in 2023/24 have been prorated for the five months of operating. However, staff costs have been assumed to commence earlier in order to support the commissioning of the new facility.
b) Please explain any incremental revenue consequences of the investment and how they can be mitigated.	The financial model indicates incremental surpluses in all year 2024/25. Sensitivity analysis has been undertaken as follows: ***Income sensitivity (Switching values):*** A 10% drop in income results in the I&E position after 10 years reducing to £0 (breakeven) assuming activity and costs remain the same. All other things being equal the MEOC model is highly sensitive to revenue funding for the planned activity and costs. If no new activity were funded in MEOC it could be used for repatriation of private work. In 2021/22 Private patient income was £3,705m across the three trusts for relevant orthopaedic work. If this private patient work were repatriated and undertaken in MEOC this would equate to 40% of planned income. Variable costs would reduce, and the deficit would be circa £1.81m over 10 years. Other private work is commissioned directly, and this information is being requested and will improve the position. ***Recruitment supplemented with locum and agency sensitivity*** Three profiles have been examined examining the impact of staffing in MEOC supplemented with locum and agency staff at a premium rate of 130% (DBTH 2022/23 average) for different profiles of recruitment and pace: • 12 months • 18 months and • 2 years While this analysis indicates that failure to recruit and the use of supplementary agency and locum staff would result in deficits in the early years the overall ability for the model to sustain an aggregate surplus after 10 years is comfortably achieved.

Case	Year	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	Total
12 months to recruit	Staff at agency rate (%)	100%	50%	0%	0%	0%	0%	0%	0%	0%	
	Months of year at agency rate	5	7	0	0	0	0	0	0	0	12
	I&E Surplus/(Deficit) £'000s	(226)	(181)	1,396	1,311	1,227	1,144	1,063	983	903	7,619
18 months to recruit	Staff at agency rate (%)	100%	50%	25%	0%	0%	0%	0%	0%	0%	
	Months of year at agency rate	5	12	1	0	0	0	0	0	0	18
	I&E Surplus/(Deficit) £'000s	(226)	(363)	1,377	1,311	1,227	1,144	1,063	983	903	7,419
2 years to recruit	Staff at agency rate (%)	100%	75%	50%	0%	0%	0%	0%	0%	0%	
	Months of year at agency rate	5	12	7	0	0	0	0	0	0	24
	I&E Surplus/(Deficit) £'000s	(226)	(581)	1,136	1,311	1,227	1,144	1,063	983	903	6,959
All recruited from start	I&E Surplus/(Deficit) £'000s	201	73	1,396	1,311	1,227	1,144	1,063	983	903	8,301

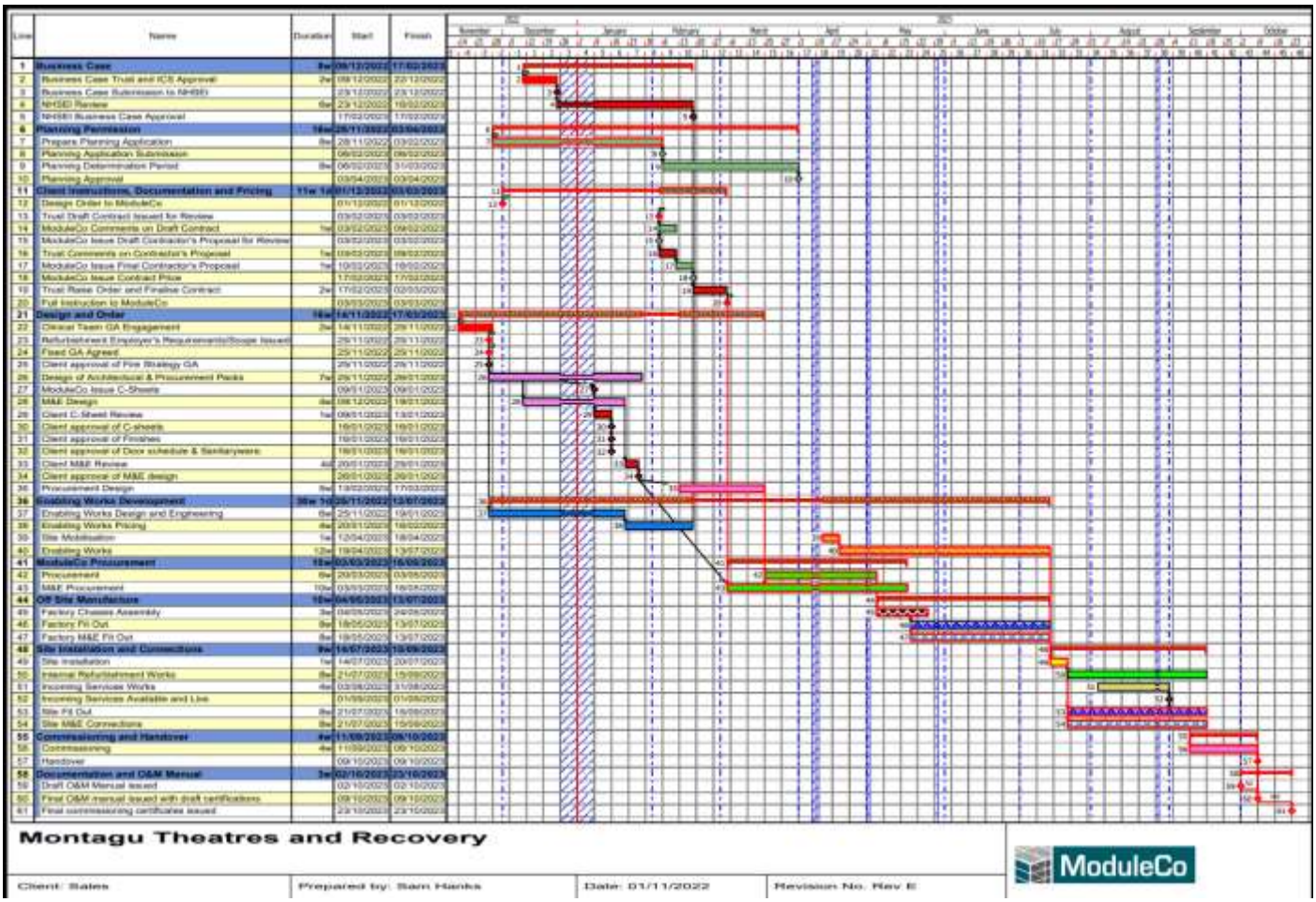
c) Are there are any cash flow issues, such as fees, enabling works, that require early funding?	Early funding of £383k has been issued in 2022/23 to support design team fees.
d) Confirm that the project can be managed within existing funding envelopes.	The MEOC initiative delivers additional activity. Discussions have been held with commissioners to confirm that this additional activity will be funded.
e) Confirm and demonstrate that the recurrent revenue cost of the scheme is affordable.	The financial model sets out the recurrent revenue position through to 2031/32. It demonstrates that after 2024/25 the recurrent revenue cost is affordable based on the assumptions set out above. Sensitivity is currently being undertaken in order to get assurance around the impact of changes to key variables with regard to income and delayed recruitment of staff. Mitigations are being investigated to manage any affordability issues such as repatriation of independent sector work.
f) Confirm the trust has assessed and is able to fund lifecycle costs to keep the facility at condition B.	The trust's cost advisers, WT Partnership, have prepared life-cycle costs associated with maintaining the new facility at Condition B. These costs will be managed through the partner trusts annual capital programmes on an equitable basis and revenue consequences of life-cycle costs are included in the overhead calculation described above.
MANAGEMENT CASE	
a) Confirm the arrangements for the management and delivery of the scheme.	***Management of the scheme*** DBTH will take formal responsibility for the management and delivery of the scheme both during the construction phase and into operation. Jon Sargeant, Deputy Chief Executive at DBTH will remain as Senior Responsible Officer for the project. The governance structure which has been put in place for development of the business case will be enhanced with a joint steering group including senior membership from each of the partner organisations. This steering group will report and make recommendations to the trust boards for each of the partner organisations through the appropriate committees. A memorandum of understanding has been developed and this will be turned into a formal contract between the three partner organisations setting out the roles and responsibilities of each and the delegated powers to DBTH for day-to-day operational and management responsibility. The memorandum of understanding and contract will also set out the financial arrangements between the organisations. The steering group will be supported by a clinical advisory group which will provide input into the detailed conversations for implementation of MEOC and subsequently provide guidance and oversight of the future development of the clinical model. The steering group will also have a reporting line through to the Acute Federation and South Yorkshire Integrated Care Board to ensure oversight of the impact of MEOC from a systems perspective. Project management responsibility will fall under the Senior Responsible Officer. The project team will be enhanced to include further representation from each of the partner organisations in order to share the workload associated with preparation for implementation and to ensure engagement and involvement in all the key details as they develop. The project management team will be include representation from the elective recovery team within South Yorkshire ICS and also relevant Commissioner and Doncaster, Barnsley and Rotherham Places. ***Delivery of the scheme*** The following embedded document sets out the programme of activities to deliver the MEOC infrastructure solution.  Montagu Hospital - Theatres, Recovery ar The following activities will be undertaken in order to prepare MEOC for operation: 1. Clinical review of detailed facility designs working with architects to sign off the room datasheets (January 2023)

	2. Clinical stakeholder engagement with best practice sites nationally three site visits and Microsoft Teams meetings (February/March 2023) 3. Recruitment activities commence (January 2023) 4. Deep dives on clinical, operating and staffing model based on areas of discussion identified during October and November 2022 clinical meetings (March/April 2023) 5. Deep dive on health equality impact of the service and design of further initiative to improve access to disadvantaged or minority groups. 6. Development of the draft memorandum of understanding into a contractual arrangement between the three organisations (April/May 2023) 7. Development of the requirement and approach to public consultation (April/May 2023) 8. Finalisation of planning permission (March 2023)
b) Confirm the key risks to delivery and measures to mitigate and manage these risks.	The key risks to delivery and measures to mitigate and manage these risks are set out in Section 3 above. The project management team will be responsible for day-to-day management of the project risk register together with escalation of key issues to the steering group.
c) Set out the benefits realisation strategy and how the Trust intend to monitor and report on benefits.	Benefits realisation will form a key part of the responsibilities of the project team and the steering group post implementation of MEOC. The key benefits will be set out as a series of measures for regular monthly reporting and will include: • Waiting list impact • Activity volumes • Theatre utilisation • Day case rates • Staffing metrics • Financial performance • Patient & Staff experience feedback These measures will be reported through the governance structure described above. The project team will hand over responsibility for benefits realisation to the operational management for MEOC once the process is embedded. It is anticipated that benefits will be included formally as part of the annual process of reviewing the contractual arrangements, aims and objectives for MEOC between the partner trusts and the ICS at the end of each operating year.
d) Set out the expectations for Post-Project Evaluation, and the expected timescales for the review of delivery.	Post project evaluation will follow standard DBTH approaches. However, given that the MEOC is a system resource the evaluation process will involve partner trusts, the ICS and wider GIRFT and national stakeholders. It is intended that a formal post project evaluation report will be prepared after one full year of operation.

Appendix 1 – [Programme Team to evaluate what data is required for collection, both for reporting and monitoring purposes, and to build necessary evidence for future SRs]

Anticipated Benefit	***Improved metrics/KPIs)***
A reduction in the size of the waiting list as a proxy to access	Pre-pandemic levels
A good, and much improved, patient experience	No cancellations due to lack of infrastructure Patient satisfaction survey
Provide orthopaedic surgery at the right time to achieve the best clinical outcome	90% of patients operated on within 12 weeks of being added to the waiting list
No constraints due to lack of theatre equipment	No cancellations or theatre delays recorded
High job satisfaction, being a part of and being proud of the service staff are delivering to the orthopaedic patients	Recruitment and retention Staff sickness Staff satisfaction
Attractive work for theatre staff: day working, no on-call night theatre provision	Recruitment and retention Staff sickness Staff satisfaction
Delivery of government waiting list targets	March 2024 No one will wait longer than 65 weeks March 2025 No one waiting longer than 52 weeks
Release infrastructure at BH, THT and DBTH	960 lists per annum
Improved use of trust theatres	48 weeks per year 8 hours per day 2 theatres
Greater standardisation of theatre consumables	Cost efficiency and safety metrics
Standardisation of anaesthesia	Cost efficiency and safety metrics
A robust and sustainable activity plan	Delivery of BC activity plan
Increased theatre throughput	4 IP cases and 4-12 DC per 8 hour list
Day case pathway for primary joint replacements	Increased lower limb arthroplasty as day cases
Overall reduction in LOS	LOS for primary joints 2.75 days and reducing
Staggered admissions for patient's 3rd plus on the theatre list	Patients admitted through day with an acceptable wait prior to surgery
Good flow, impacting on theatre throughput	Lists start on time
Shortest possible gap between cases in theatre	Gap between cases
Theatre time used	Knife to skin time
Patient experience	Patient feedback/PROMs

Appendix 2 – Schedule of Works (to be attached by Trust)



Appendix 3 – OB Forms (to be attached by Trust)

Microsoft Excel
97-2003 Worksheet

Appendix 4 – Key Estates Information [to be evaluated and adjusted for each individual programme]

KEY ESTATE METRICS	
Total Area of Building m^2	1,607.3m²
New build clinical GIA m^2 and % of total GIA	408.8m² and 25%
New build non-clinical GIA m^2 and % of total GIA	161.5m² and 10%
Refurbishment clinical GIA m^2 and % of total GIA	1,023.9m² and 64%
Refurbishment non-clinical GIA m^2 and % of total GIA	13.1m² and 1%
No. of beds and type	12 no Surgical
PFI Estate Implications - Is the build on an existing PFI Estate? - Does the build interface with any PFI Estate? - Are there any other implications with the PFI Contract that need to be considered?	No
MMC (Modern Methods of Construction) Status. Percentage to be achieved and brief overview	35% of the scheme will be delivered through MMC. Details with regard to MMC are included in Section 5.
Summary of any significant derogations and assurance (derogations template is available)	There are a few minor derogations within the scheme which will be reviewed during the detailed design process and either addressed or accepted as part of the scheme.
£ Reduction in BLM	£26,880
Any temporary accommodation required – provide details	Not applicable – Rehab beds used for surgical will be managed
Is a land purchase required – provide details	Not applicable
Is this an owned or leased facility – provide details if leased	Not applicable
Stage of design development and trust approval (please attach design drawings)	Stage 2 Concept Design. MEOC-PHS-XX-XX-D-R-A-002_Site Develop
Estimated average lifecycle costs £/m2 over asset life	

Appendix 5 – Equality Impact Assessment

Business area:	Musculoskeletal Services
Team/Department:	Orthopaedics
Date completed:	November 2022
Name(s) of author(s):	James Nicholls

Name of policy / guidance / strategy / proposal / operational activity etc. – Highlight here if this is related to COVID-19
Montagu Orthopaedic Elective Surgical Hub

What are the aims, objectives and projected outcomes?

- Reduction in the length of time patients are waiting for elective surgery to at least the national recovery targets
- Implementation of the best orthopaedic pathways of care including more day case pathways and an overall reduced length of stay for IP's. These pathways have been co-designed (and tested) with staff and service users based on national guidelines
- Increased elective operating above baseline activity levels
- Removal of historical constraints and dependencies in running the elective service on the acute site
- Stop the cancellation of patients due to lack of infrastructure
- The establishment of a centre of excellence for orthopaedic surgery in which staff aspire to work within and do the job they have chosen to do. Employing sufficient, happy and cared for staff.
- Creation of an integrated MDT working environment which facilitates improved collective care and decision making with the right physical infrastructure within the unit
- A new service delivery model with innovative, effective and efficient patient pathways to maximise value and remove delays and waste which are aligned to GIRFT
- High levels of patient satisfaction gained through a reduced wait for surgery, a better predictable environment, MDT working and reduced length of stay

Section 1: EQUALITY INFORMATION

1.1 What relevant quantitative and qualitative information (data) do you have? This may include national or local research, surveys, reports or research; workforce / patient data; complaints and patient experience data, etc.

	Positive Impact This will actively promote or improve equality of opportunity or address unfairness or tackle discrimination	**Negative Impact** This will have a negative or adverse impact which will cause disadvantage or exclusion	**Neutral Impact** There is no likely impact on any of the protected groups	**Does it advance equality of opportunity? (Y/N)**	**Does it eliminate unlawful discrimination? (Y/N)**	**Does it foster good relations between people? (Y/N)**
Race (including nationality)	**The scheme will deliver waiting list reductions for all members of the relevant populations irrespective of race**			**Y**	**n/a**	**n/a**
Religion/belief and non-belief			**The scheme will treat patients already on the waiting**	**n/a**	**n/a**	**n/a**

			list. There is no bias here			
Disability	**More patients with disability will be treated due to the volume of activity delivered by MEOC and the release of capacity at host sites.**			**Y**	**n/a**	**n/a**
Sex			**The scheme will treat patients already on the waiting list. There is no bias here**	**n/a**	**n/a**	**n/a**
Gender Reassignment			**The scheme will treat patients already on the waiting list. There is no bias here**	**n/a**	**n/a**	**n/a**
Sexual Orientation			**The scheme will treat patients already on the waiting list. There is no bias here**	**n/a**	**n/a**	**n/a**
Age			**The criteria for admission will allow access to patients of all ages who are suitable for MEOC pathways.**			
Pregnancy and Maternity			**The scheme will treat patients already on the waiting list. There is no bias here**	**n/a**	**n/a**	**n/a**
Marriage and Civil Partnership			**The scheme will treat patients already on the waiting list. There is no bias here**	**n/a**	**n/a**	**n/a**
Human Rights (FREDA principles)			**The scheme will treat patients already on the waiting list. There is no bias here**	**n/a**	**n/a**	**n/a**

Carers	**In treating patients, to help them cope better. Also, we are moving away from an environment where short notice cancellations are common which can cause extreme difficulties for carers due to the planning required.**			**Y**	**n/a**	**n/a**
Other groups e.g. Gypsy, Roma, Travellers, vulnerable adults or children (e.g. homeless, care leavers, asylum seekers or refugees)	**Again, these people tend to be in IMD 1 & 2 which is over represented on the current waiting list and will be treated faster.**					

1.2 List any specific equality issues and information gaps that may need to be addressed through engagement and/or further research
The location of MEOC in the Mexborough Hospital allows equitable access to patients from Doncaster, Rotherham and Barnsley. There is excellent parking and good public transport. Patient transport will be laid on where travel is a barrier to care which will be agreed at pre-assessment.

Section 2: ANALYSING THE EQUALITY INFORMATION

In this section record your assessment and analysis of the evidence. This is a key element of the EIA process as it explains how you reached your conclusions, decided on priorities, identified actions and any necessary mitigation.

2.1 Analysis of the effects and outcomes
Through delivery of high volumes of surgery with excellent outcomes in a modern facility with good transport links and excellent parking the MEOC facility will improve access to all patients on its waiting list therefore reducing inequalities.

Section 3: OUTCOME(S) OF EQUALITY IMPACT ASSESSMENT

No major change needed	Adjust the policy/proposal	Adverse impact but continue	Stop and remove the policy/proposal
X			

Appendix 6 – Letters of support

Letters of support will be agreed and appended here as the business case passes through the governance process.

Appendix 6 – Digital capability KLOEs

Digital Capability KLOE's	*Yes/No*	*Narrative*
Must Haves		
Transformation There are policies in place and the transformation is embedded for: • Digital preoperative assessment • Digital prehabilitation tools • Digital consent • Keeping in touch with patients while they wait • Alternatives to digital contact where required	Yes	DBTH is progressing through a business case process to procure and implement a new EPR. The key business needs which this will address reflect the Digital Capability KLOE's and include: • Digitise patient interactions: Patients will be able to interact and provide updates to teams in ways more efficient than the existing physical appointment process. Through a single patient portal, they will be able to see when their next appointment is due (helping to reduce the likelihood of missed appointments), access results and information related to their own healthcare needs. • Improve user experience: This will be achieved by using fewer systems and adopting more streamlined access methods whilst retaining high levels of security. • Deliver enabling technology: The Trust will implement systems that improve technology that supports the ability of teams to care for patients rather than be viewed as an administrative barrier. • Provide relevant tools for the role: The Trust will implement digital technology that allows carers to remain at the patient's side when updating or viewing information with devices which are relevant to the environments in which they are operating. Tools such as tablet computers, smart phones, and wearable devices will all have a place as part of digitally connected ways of working. • Ensure accurate and timely data at the point of care: This will improve the speed at which analysis can be made and improve the accuracy of decisions. The data acquired through daily activity will be proactively placed back into the hands of clinicians, managers, leaders and decision-makers through compelling self-serve reports and dashboards. • Implement a fully digitised end to end process: This will have administrative and clinical benefits by removing the need to manually collate and process paper charts across every bed. Instead, activity can be easily prioritised based upon recorded observational feedback. Digitising core activities, such as observations, will lead to improved patient care, safety, and reduced costs. Safety will be further improved as the reliance on interpreting handwritten notes will be removed with the introduction of clinical noting. • Data sharing and interoperability: At an organisational level, the success of the strategy will be proven when digital is regarded by patients, staff, and health economy partners as a key enhancement to every clinical pathway and embedded as a way of working.

Systems We will have established systems for: • Electronic appointment management • Clinic scheduling/worklists • Theatre allocation • The use of digital triage	Yes	Existing digital provision is largely in place for these areas but the advent of a new EPR at DBTH will enhance current capabilities and ensure that digital requirements for the MEOC are comprehensive.
Accessibility • Integrated Care Records and Interoperability to existing ICS systems to support the data flows • Shared diagnostic imaging from all organisations to prevent the duplication of testing • Access to patient records within ICS as a minimum - a shared care record that allows information to follow the patient and flow across the ICS. Links to external ICS partners: private, dentistry, community, social care and ambulance • One time login for clinical and operational staff - providing access to all clinical information around the surgical hub	Yes	DBTH will act as host for the digital requirements of the business case and provide access as required to partner providers to support processes such as booking for MEOC. ICE Open Net already provides blood results from all SY Trusts to other SY Trusts
Should Haves		
Connectivity • Adoption of cloud-based services where feasible • Use of virtual consultations and integration with wearable devices where appropriate • Connectivity requirements: wifi, 5G …	Yes	DBTH anticipates moving its EPR to a cloud based system and adopting best practice connectivity across and within its sites. Suitable digital innovations will be adopted and adapted to support the MEOC model of care and will be developed alongside existing initiatives.
Innovation There will be aspirations to: • Share continuous improvement and innovation of digital solutions to surgical care • Using Artificial Intelligence within the surgical hub • The use of Robotic Process Automation to improve processes. E.g. - Automated patient feedback - RPA, output of dashboard.	Yes	SY ICS and the partner trusts are ambitious with regard to the development of digital and IT enablers to support pathways of care. The programme of activities through to implementation of the new MEOC will ensure that existing technology is adopted and ongoing development of the service will seek to exploit digital innovation appropriately, working with clinical and operational staff.

5.2. Barnsley Hospital NHS Foundation Trust Children's Services Developments

For Assurance

Presented by Bob Kirton

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/02/02/5.2

SUBJECT:	**BARNSLEY HOSPITAL NHS FOUNDATION TRUST CHILDREN'S SERVICES DEVELOPMENTS**					
DATE:	2 February 2023					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval	✓		*Assurance*	✓	
	For review	✓		*Governance*	✓	
	For information			*Strategy*		
PREPARED BY:	CBU 3 Management Team and Paediatrics.					
SPONSORED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive Jackie Murphy, Director of Nursing and Quality					
PRESENTED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive					

STRATEGIC CONTEXT

Best for Patients and Public: We will provide the best possible care for our patients and service users.

In 2018/19, a major capital funding bid, to the value of £3.2m, was approved by the South Yorkshire & Bassetlaw Integrated Care System regarding the redesign of Paediatric In-Patient Services at Barnsley Hospital NHS Foundation Trust. The project was centred on a new build, co-located and integrated Children's Emergency Department (ED) and Children's Assessment Unit (CAU) and also included remodelling and relocation of the paediatric in-patient ward with a reduced bed base of eight beds, addressing the ward staffing level issues highlighted by the CQC in 2017. A review of the Children's Community Nursing (CCN) Team was also carried out to ensure appropriate out of hospital care in support of the reduced bed base and the 24/7 ED/CAU.

EXECUTIVE SUMMARY

The attached paper provides an overview of the benefits realised as a result of the above developments as well as describing any deviations, unplanned benefits and future plans.
Key benefits achieved include:

- Significant pathway development leading to a better experience for children and families, focussing on care being provided outside of the hospital setting
- Co-location of Children's ED and CAU leading to more streamlined and seamless pathways for children accessing emergency care
- Environmental improvements to Children's ward, Children's ED and CAU leading to a better experience for children, families and staff, with changes being informed by large scale stakeholder engagement
- Reduction in in-patient bed base, leading to compliance with safe staffing levels
- Reduction in in-patient admissions through establishment of 24/7 CAU, leading to a better experience for children and families due to expedited discharge with appropriate community support.

RECOMMENDATION

The Board of Directors is asked to review the attached paper, noting progress, positive developments and ongoing work.

This paper links to the staff story video that was presented at the last public Board: https://vimeo.com/771169755/96b421e2f6

BENEFITS REALISATION REPORT

Project:	**BHNFT Children's Services Developments** • Children's Emergency Department • Children's Assessment Unit • Children's Ward • Children's Community Nursing Team
Date:	**August 2022**
Submitted By:	**Tracy Taylor** Associate Director of Nursing **Deena Goodhead** Service Manager **Ben Dockerill** Matron **Beverly McGeorge** Business Manager
CBU / Department:	**Children's Services, CBU3**
Executive Sponsor:	**Jackie Murphy** Director of Nursing and Quality
Business Sponsor:	**Tracy Taylor** Associate Director of Nursing

Benefits Realisation Governance

Document Location

This document is only valid on the day it was printed.
The source of the document will be found on the project's PC.

Document Revision History

Revision date	Previous Revision Date	Summary of Changes
12/07/2022	-	Final draft for review pre-ET 20/7/22
15/07/2022	12/07/2022	Paper reviewed at ET agenda review meeting – postponed to Aug. Paper to be refocused following comments from BK/JM/CT/SE
27/07/2022	-	New draft for review by CBU and JT
29/07/2022	27/07/2022	Reviewed by JT and BD – comments made
02/08/2022	27/07/2022	Reviewed by TT – comments/changes made
02/08/2022	02/08/2022	Final draft to GB for PMO review
03/08/2022	02/08/2022	Reviewed, amended and comments from BD
04/08/2022	02/08/2022	Reviewed, amended and further comments made by GB
05/08/2022	04/08/2022	Further amendments by TT
05/08/2022	05/08/2022	Reviewed, amended and further comments from BK
05/08/2022	05/08/2022	Final version sent out for review prior to ET papers 8/8/22
08/08/2022	05/08/2022	Final version

PMO Reviewed

Name	Title	Date	Comments
Gavin Brownett	Associate Director of Strategy and Planning	04/08/2022	Reviewed, amended and further comments made

Business Case Tracker ID:

CBU Management Team Approval

	Role	Signature	Date
CBU Approval:	Executive Sponsor	**Jackie Murphy**	**04/08/2022**
	Clinical Director	**Jo Butterworth**	
	Associate Director of Operations	**Shaun Garside**	
	Associate Director of Nursing	**Tracy Taylor**	**04/08/2022**
	CBU Accountant	**Samara Ridge Wood**	
Not Approved:	<Enter reason>		

Governance Committee Approvals

Executive Team Approval

Date of meeting:	10/08/2022	**Outcome:**	Approved
Comments:	F&P presentation not required – straight to Trust Board		
Outcome Reported to Proposer:	Yes / No	**Date:**	

Trust Board Approval

Date of meeting:		**Outcome:**	Approved / Not Approved
Comments:			
Outcome Reported to Proposer:	Yes / No	**Date:**	

1. Background

In 2017, the Care Quality Commission (CQC) inspection of Barnsley Hospital NHS Foundation Trust (BHNFT) Children and Young People's (CYP) services recorded that: "National guidance was not followed to determine staffing ratios on the children's ward and the trust had not used an acuity tool." In response, an independent nursing peer review was commissioned by the Clinical Business Unit (CBU) and highlighted that staffing levels on the paediatric in-patient ward and the current Children's Assessment Unit (CAU) were not in line with Royal College of Nursing (RCN) Safer Staffing (2013) recommendations. Shortfalls were being addressed largely by the use of agency staff.

In 2018/19, a major capital funding bid, to the value of £3.2m, was approved by the South Yorkshire & Bassetlaw Integrated Care System regarding the redesign of Paediatric In-Patient Services at BHNFT. This included a new build development of a co-located and integrated Children's Emergency Department (ED) and CAU and remodelling of the paediatric in-patient ward which would be relocated from its current location in KL-block to O-block and, based on activity data, the ward bed footprint would be reduced to twelve beds. This would be complemented by a nine bedded CAU to be co-located with the Children's ED and operating on a 24/7 basis. The business case also described a further development in terms of extension of the adult majors' provision which would be facilitated by this new build, though this element of the business case is out of the scope of this benefits realisation paper.

Following the successful capital funding bid, and in support of the re-design of the in-patient ward in particular, a paper was submitted to the BHNFT Executive Team relating to how the agreed reduction in bed base would be achieved and identifying the appropriate paediatric nurse staffing levels required for the new in-patient bed base, as well as supporting the co-located ED/CAU. The planned reduction in bed-base was also seen as an opportunity to achieve compliance with RCN recommended staffing levels.

In conjunction with the ED/CAU development and ward reconfiguration, a review of the Children's Community Nursing (CCN) Team was carried out and a proposal for a future service model for the CCN Team was submitted in order to ensure sustainability of the new ward model with its reduced in-patient bed base and the 24/7 ED/CAU. This paper proposed additional investment in an extended CCN team, including the establishment of a Children's Acute Rapid Response Team (CARROT). Three options were discussed in the paper, with highlighted Option 3 being approved:

- Option 1: No CARROT service; maintain current CCN Team opening hours of 8 hours a day, 5 days a week
- Option 2: CARROT service opening hours 8 hours a day, 7 days a week
- **Option 3: CARROT service opening hours 12 hours a day, 7 days a week**

Subsequently, following review of activity data, the decision was taken to further reduce the in-patient ward bed base to eight beds with the release of nurse staff budget associated with the lower bed base being used to increase Tier 2 (Specialty Doctor/Registrar level) medical staffing levels across CAU and the ward, as well as facilitating an increase in ward clerk support. This would be achieved within the planned financial envelope outlined in the original staffing paper.

This paper will therefore provide an overview of the benefits realised as a result of the developments encompassed in these three projects:

- Children's In-Patient Ward Relocation and Reconfiguration
- Children's Emergency Department and Assessment Unit Development
- Children's Community Nursing Team Development

It should be noted that in terms of the financial aspects of the three projects, this paper does not consider performance against the capital budgets allocated to the Children's Ward refurbishment and ED/CAU development as these were project managed by Barnsley Facilities Services and monitored via the Trust Capital Monitoring Group. Operational responsibility for implementation of the three projects sat with Children's Services within CBU3 and this paper will review the revenue budgets associated with that implementation, specifically those related to staffing. The capital spend profile for this project has been previously reported to assurance committees and Trust Board via capital monitoring updates.

2. Project Aims and Objectives

For the purpose of this paper, 'The Project' will encompass the following elements, as described within section 1:

- Paediatric In-Patient Redesign and Associated Nurse Workforce
- Children's ED / CAU Development Combined Business Case
- Children's Community Nursing Development

2.1. Aims and Objectives

The aims of the project were to:

- Implement a staged approach to the reduction and consolidation of the paediatric in-patient bed base
- Reduce the known risks to quality, safety and patient experience within the paediatric in-patient service by achieving compliance with Royal College of Nursing (2013) (RCN) safe staffing guidance and CQC recommendations
- Bring together the Children's Emergency Department (ED) and Children's Assessment Unit (CAU) into a co-located integrated model of care

- Establish a future service model for the Children's Community Nursing (CCN) Team which will ensure sustainability of the new acute paediatric service delivery model

The objectives of the project were to:

- Reduce overall reliance on inpatient beds, improving the resilience of the service to manage within an established bed-base by reducing the number of avoidable paediatric attendances, admissions and re-admissions to secondary care that could be safely managed in the community
- Develop processes and pathways around admission and discharge
- Implement a staffing model which is fit for purpose and operational prior to the move to the new ED/CAU facility
- Provide increased direct access to CAU for Children & Young People (CYP) that require intervention following initial discharge
- Provide consistency in CAU service provision over 7 days
- Deliver a better patient experience for Children and Families accessing urgent and emergency paediatric care
- Improve the clinical relationship between Children's ED and CAU teams in order to more collaboratively manage medically unwell children
- Provide bespoke facilities for patients attending with mental health needs
- Facilitate early clinical assessment and follow up at home, ensuring effective liaison between all agencies, by providing a CCN in-reach service to the CAU and the Children's ward and working in partnership with Children's ED
- Promote the health and well-being of the unwell child and family through health education and support
- Provide training to families, schools, nurseries and private agencies that provide continuing health care to children

2.2. Project Scope

In Scope

- Paediatric Ward Capacity and Associated Staffing Model
- Co-location of CAU and Children's ED
- CAU Capacity and Opening Hours
- CCN Team development

Out of Scope

- Capital expenditure re ward and ED/CAU
- Majors Capacity
- Single Point of Entry
- New Ambulance Entry

3. Benefit Realisation

3.1. Summary of Benefits

The table below summarises whether the anticipated benefits have been realised along with how they would be measured and the expected impact. The details of baseline metrics and post-implementation metrics are described in section 3.2.

Key:

Achieved:	✓	Not Achieved:	✗	Partially Achieved	✓ ✗

Type*	Benefit	Metric	Impact	Achieved
NCR	Compliance with RCN (2103) safe staffing recommendations	RCN safe staffing recommendations: 1:3 wte:bed under 2 1:4 wte:bed 2 and over	Reduction in clinical risk as a result of poor staffing levels	✓
QL	Facilitation of pathway development	Range of pathways developed and implemented (see Appendix 1)	Clear processes and pathways implemented in relation to admission and discharge	✓
QL	Improved patient experience for children and families accessing urgent and emergency paediatric care	Family and Friends Test results Complaints and concerns	Improved FFT results Reduction in complaints and concerns	✓
QL	Improved facilities for staff working in paediatric services	Survey monkey May 2021 Peer review exercise June 2022	Improved staff satisfaction and morale through consultation	✓
QL	Improved environment within Children's ED and CAU, meeting expectations of children and families involved in consultation	PLACE scores Stakeholder consultation	Improved PLACE scores Achievement of output from stakeholder events	✓

Type*	Benefit	Metric	Impact	Achieved
NCR	Improved resilience within children's ED by streaming appropriate patients to CAU	Attendances to Children's ED Re-attendances to Children's ED ** Waiting times in Children's ED	Reduction in attendances to Children's ED Reduction in re-attendances to Children's ED Maintain compliance with ED access target	✗ ✓ ✗ ✗
NCR	Specialty able to manage within new, reduced bed base by streaming appropriate patients to CAU and CCN team	Activity data for Children's Ward and CAU	Reduction in admissions to Children's Ward Increase in ward average length of stay Increase in patients seen on CAU	✓ ✓ ✓
QL	Provision of an in-reach service	Service provision	Service and operational sustainability and positive patient experience	✓
QL	Provision of an IV antibiotic community service	Service provision	Service and operational sustainability and positive patient experience	✓ ✗
QL	Participation in and alignment with multi-agency provider priorities	Involvement with South Yorkshire and Bassetlaw (SY&B) system-wide workstreams pertaining to Children's Services	Alignment to strategic intent with local partners re. Children's service	✓
QL	Increase awareness in schools, nurseries and private agencies regarding continuing health needs	Training provision in schools, nurseries and to private agencies	Better management of children with continuing health needs in community	✓ ✗

* CR – Cash Releasing, NCR – Non-Cash Releasing, IG – Income Generation, QL – Qualitative

*** denotes any child who presented to ED and who had at least 1 or more attendance in the preceding 12 months for the same reason*

3.2. Detail of Benefits

3.2.1. Compliance with RCN (2103) Safe Staffing Recommendations

Following the 2017 Care Quality Commission (CQC) inspection of BHNFT Children and Young People's (CYP) services it was recorded in the trust report that: "National guidance was not followed to determine staffing ratios on the children's ward". Additionally, an external peer review visit highlighted that staffing levels on Ward 37 and CAU were not in line with Royal College of Nursing (2013) Safer Staffing recommendations.

It was concluded that the funded nursing establishment was no longer sufficient to meet safer nurse staffing requirements on ward 37 (inpatient ward) and the CAU for the inpatient bed base of 20 and the current CYP Registered Children's Nurses (RCN) workforce model presented risks to the quality of care delivery and the patient experience of the service.

A proposal for change was submitted to the Executive Team in August 2019, comprising two elements:

1. Identify how the agreed reduction in bed base will be achieved
2. Identify what appropriate paediatric nurse staffing is required to support this reduction in inpatient bed base.

It was proposed that the in-patient bed base would be reduced from 20 to 16 by July 2019, followed by a further reduction to 12 beds by January 2021. Likewise, the CAU would concurrently increase opening hours to 12 hours/day seven days /week from July 2019 to reach a 24-hour 7-day service by January 2021.

Subsequently, based on updated bed modelling data and a robust risk assessment, it was agreed to further reduce the in-patient bed base to eight beds, complemented by the nine beds on the 24/7 CAU. Further agreement was reached to proactively use the CAU for patients needing a short overnight stay so as to limit the number of short stay patients on the in-patient ward. This would reduce overall reliance on inpatient beds and improve the resilience of the service in managing within an established bed-base.

In order to ensure the success of the remodelling of the in-patient bed base, it was important that substantive staffing levels should be appropriate, with in-built flexibility to increase in-patient beds should they be required to meet unexpected demand.

Feedback from the peer review visit highlighted that staffing levels on Ward 37 and CAU were not in line with Royal College of Nursing (2013) Safer Staffing recommendations which include RCN to patient ratios of:

- 1:4 >2years old
- 1:3 <2 years old
- 1:2 High Dependency Care (HDU)

Trust data showed the average age of the patient population for CYP's services in 2017/2018 was 3 years old therefore it was agreed that the future nurse to patient ratio would be set at 1:4.

In addition, the Royal College of Nursing (2013) Safer Staffing recommendations include:

- A minimum of two Registered Children's Nurses (RCN's) in all inpatient and day case areas
- A supernumerary Agenda for Change (AFC) Band 6 RCN patient flow coordinator to facilitate a situational awareness and be a point of contact for medical and nursing staff
- A Practice Educator to ensure the continuing education of staff and the clinical care is evidence based and of a high quality

In order to achieve the above, the following phased approach was proposed:

Date	Beds	CAU	Other
Pre-change	20	M-F 10:00 – 21:00 S-S 09:00 – 13:00	
Q2 2019/20	16	M-S 12hrs/day	Min 2 RCN per shift Uplift B5 vacancies to B6 Practice Educator
Q1 2020/21	12	M-S 24hrs/day	B6 Patient Flow Co-ordinator

The ultimate bed base for the Children's ward was subsequently reduced from twelve beds to eight, facilitating the required medical and A&C staffing model for CAU and the Children's Ward.

A full review of staffing across Children's Services was carried out to facilitate safe staffing of both the new Children's Ward and the co-located ED/CAU and the following actions were taken:

- Existing staff were split between the Children's Ward and ED/CAU based on staff preference and ensuring appropriate skill mix
- All vacancies and new posts were recruited to in order to ensure appropriate staffing levels
- Agreement reached to utilise staff flexibly across Children's Services as a whole to ensure safe staffing levels in all areas at all times
- Full Patient Flow Co-ordinator team established
- Practice Educator Team established to oversee training and education needs across Children's Services

Since the relocation of the Children's Ward from Ward 37 to the former Ward 14 in January 2020, the service has managed demand for admissions within the new, reduced in-patient bed base of eight beds and CAU bed capacity of nine (total of 17 beds across the service). This has been made possible due to the ability to utilise CAU bed capacity flexibly as the unit can now accommodate patients for up to 24 hours, and with the potential to flex additional ward beds should this be required.

Over the last 18 months, due to this flexibility in service capacity, it has not been necessary to close the Children's Ward or CAU to admissions. The ward has had to flex above the established eight beds on a handful of occasions to meet peaks in demand. This has been achieved by utilising the patient flow coordinators or lead nurses to support with nursing care.

In addition, the ward has been able to offer support to other local Trusts in terms of taking diverts from across SY&B due to the ability to flex ward capacity at times where other units were full. The flexibility offered by the new service structure allows BHNFT to support children and families from across SY&B leading to improved patient experience and limiting the impact of diverting these families out of area.

3.2.2. Facilitation of Pathway Development

Appendix 1 shows a full list of the clinical pathways planned as part of the Children's Ward and ED/CAU developments, including whether they were achieved. Key pathways and associated benefits included:

- **GP > CAU Pathway**

This pathway streamlines acute access from GP to Children's Services via Patient Flow Co-ordinators who are able to assess and signpost to the most appropriate area (ED or CAU) using agreed referral criteria. The team worked with colleagues in Barnsley Clinical Commissioning Group (BCCG) to ensure full awareness of the new process across the Barnsley Primary Care Network. The more streamlined pathway improves patient experience as access times are reduced with patients being seen more quickly in the appropriate area rather than the traditional model of ED>CAU>Ward.

This new pathway utilises the introduction of the new role to the service of patient flow coordinators which are not generally utilised in Children's services at DGH's. As a result, BHNFT partner agencies are able to access the service directly which improves referral times and allows for a more appropriate route into the service for children and families.

GP to CAU referrals are currently recorded as attendances but the service plans to review with partners how they should more appropriately be recorded in future, taking into account other SDEC pathways.

- **Ambulance > Children's ED**

This pathway has enabled ambulance turnaround time targets to be achieved within Children's ED. In the last six months, the average turnaround time has not exceeded 16 minutes. This is due to having an individual waiting area for children and the ambulance crews now liaising directly with the Children's nursing staff, allowing them to bypass the long waits within the adult services.

Previously, children brought to ED by ambulance would wait in the same ambulance handover queue as adults. This new pathway has led to a quicker triage time due to the dedicated streaming of patients into Children's ED, contributing to the overall resilience of the service.

- **Children's ED > CAU**

The co-location of CAU with Children's ED facilitates the transfer of patients from ED to CAU at times of peak demand. This improves patient experience by enabling patients to move to CAU to be assessed by the paediatric medical team. This also supports compliance with the 4 hour access target. CAU has paediatric medical staff resident on the unit allowing for support and oversight 24 hours a day. This also ensures that patients' lengths of stay are reduced due to timely access for review and discharge.

- **CAU > Children's Ward**

This pathway ensures appropriate transfer of patients from CAU to ward depending on clinical condition, ensuring that those children requiring under 24-hour stays are cared for on CAU rather than occupying an in-patient bed. Conversely, this collaborative and integrated approach enables the ward to support CAU flexibly, taking some short stay patients at times of peak CAU demand, to ensure patient flow is not impacted.

- **CCN Team Referral**

This pathway allows direct referral from CAU and the ward to the CCN team for a range of conditions, supporting expedited discharge and compliance with national standards for hospital at home care. The expansion of this service to seven days has allowed additional support for families who do not require a hospital stay but still need health care provision. These children are able to receive a range of support at home, from administration of medications and monitoring of clinical observations to support and reassurance for parents at a time where anxieties may be increased. Due to care at home, parents do not have the added problem of arranging support for other children and are cared for in their own environment which reduces stress and anxiety.

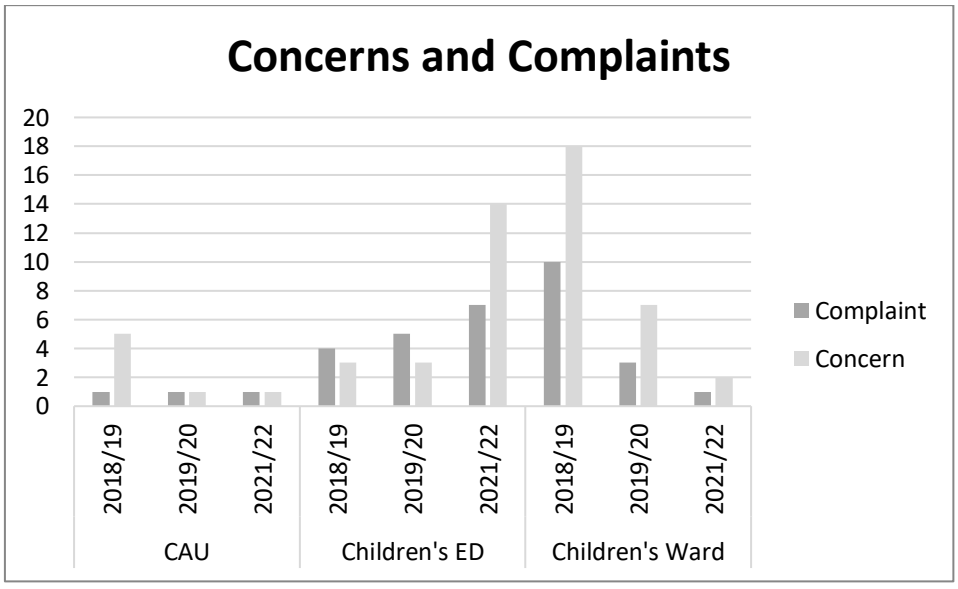
Families with children with complex long-term conditions are able to access support at weekends for issues such as replacement feeding tubes which would usually result in a hospital attendance. This again reduces stress and anxiety for the child and family and improves patient experience. It also reduces the impact on primary care as these families are not seeking advice elsewhere as they can access support from a service they know and who know their child's needs.

Information about the impact of these referral pathways on activity within Children's services can be found in section 3.2.7.

3.2.2. Improved Patient Experience for Children and Families accessing Urgent and Emergency Paediatric Care

3.2.2.1. Compliments, Concerns and Complaints

Analysis of concerns and complaints has shown a reduction in those received in relation to CAU and the Children's Ward but an increase has been seen in the number of concerns received relating to Children's ED. Numbers are relatively small in terms of complaints and no particular theme in the nature of the concerns has been seen. In general, concerns relate to waiting times and medical care which are outside the control of Children's services being under the remit of CBU1.

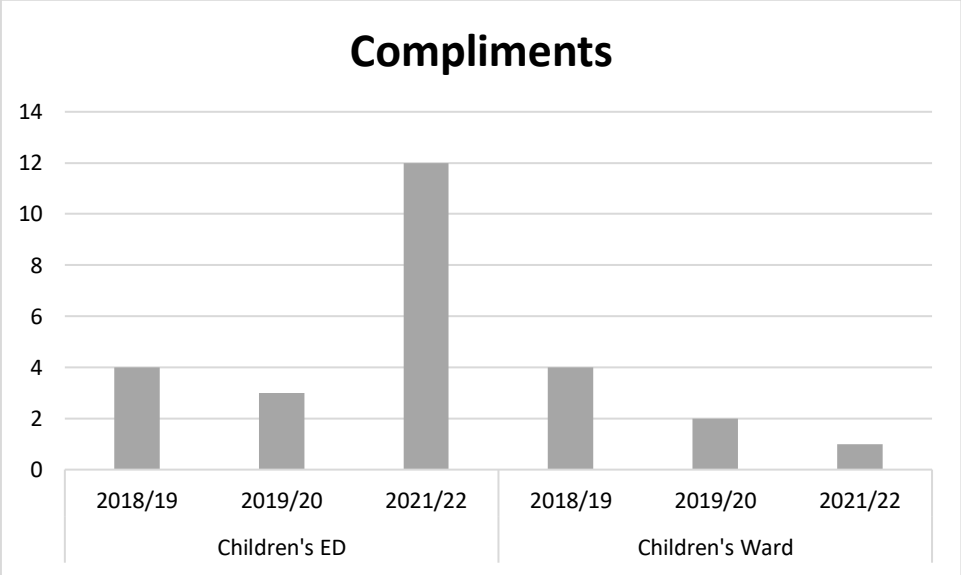


Taking concerns and complaints together, across Children's ED, CAU and the Children's Ward, the table below shows the overall impact of the service changes on concerns and complaints. In 2021/22, the service received 26% fewer concerns and complaints than in 2018/19. This information also needs to be considered in light of the acknowledged increase in patient dissatisfaction with NHS services following the Covid-19 pandemic which has, in most areas, resulted in an increase in concerns and complaints.

Year	Number of Concerns/Complaints	% increase/decrease since 2018/19
2018/19	53	
2019/20	27	-49%
2021/22	42	-26%

Conversely, analysis of compliments received has shown a marked increase in the number of compliments received relating to Children's ED since the opening of the new unit, with overall compliments across Children's services having increased by 38% since 2018/19.

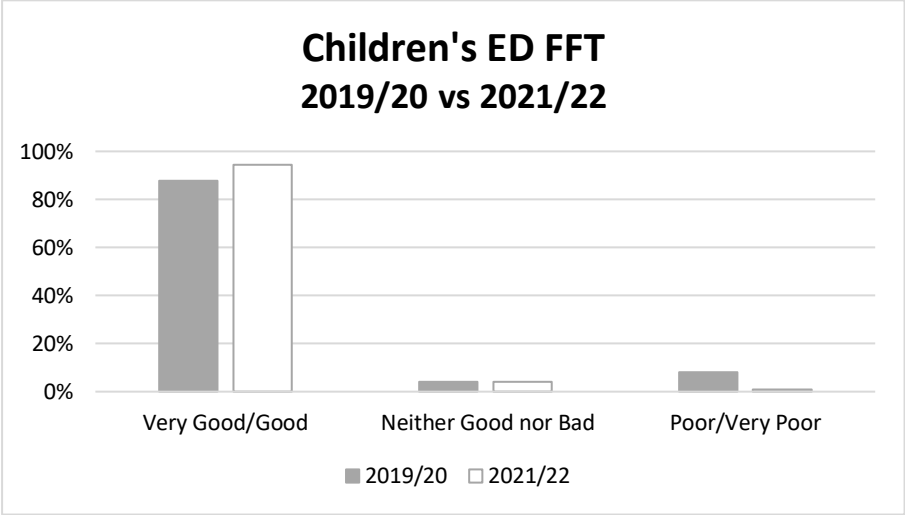
Year	Number of Compliments	% increase/decrease since 2018/19
2018/19	8	
2019/20	5	-38%
2021/22	13	38%

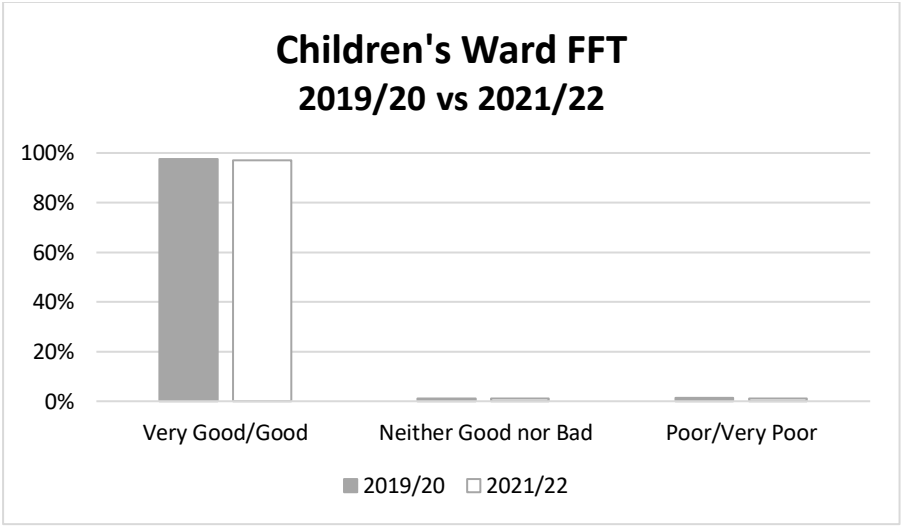


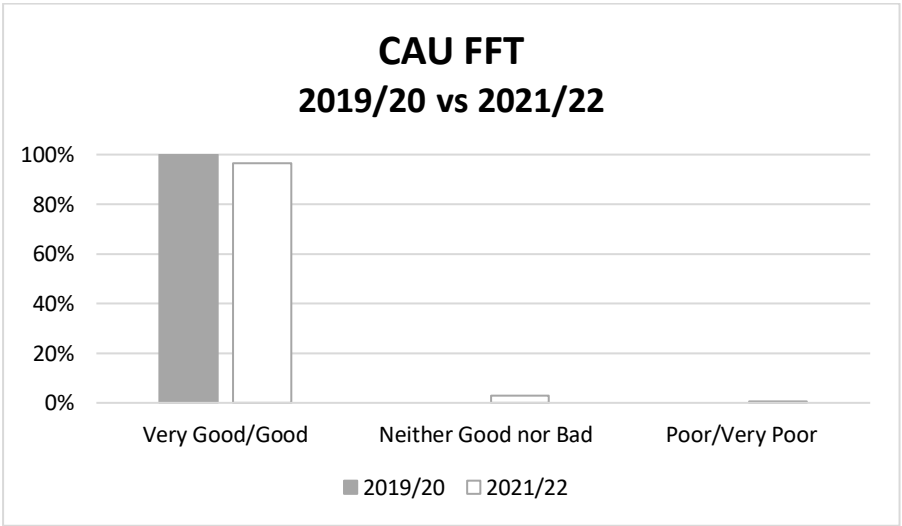
3.2.2.2. Friends and Family Test

The following charts compare overall ratings from the Friends and Family Test (FFT) for Children's ED, Children's Ward and CAU for 2019/20 and 2021/22. The categories for responses to the initial question on the FFT form, which gives the overall rating, changed between the two years. For readability, the 2021/22 wordings have been used in the charts.

It can be seen that the % of Very Good/Good ratings has increased with a decrease being seen in all negative ratings.


Children's ED FFT
2019/20 vs 2021/22
100%
80%
60%
40%
20%
0%
Very Good/Good
Neither Good nor Bad
Poor/Very Poor
2019/20
2021/22


Children's Ward FFT
2019/20 vs 2021/22
100%
80%
60%
40%
20%
0%
Very Good/Good
Neither Good nor Bad
Poor/Very Poor
2019/20
2021/22


CAU FFT
2019/20 vs 2021/22
100%
80%
60%
40%
20%
0%
Very Good/Good
Neither Good nor Bad
Poor/Very Poor
2019/20
2021/22

3.2.2.3. Survey Monkey - July 2022

In July 2022, two Survey Monkeys were started to ask users of the ED/CAU and CCN team services what they thought of the new provision. The results of these surveys will be added to further iterations of this paper ready for Trust Board.

3.2.3. Improved facilities for staff working in paediatric services

In its 2015 publication, "*The impact of physical environments on employee wellbeing",* Public Health England (PHE) stated that:

The surroundings in which employees spend their working lives are an important source of job satisfaction and impact on work motivation and patterns of interaction. They can be as much of a source of pressure as a heavy workload, poor work-life balance or significant organisational change.

The provision of an improved environment within the new ED/CAU is therefore seen as vital to the efficient and effective functioning of the new unit. PHE went on to say that:

"the office layout, office furniture, workplace lighting and temperature and employee control over their work environment are all factors which should be considered in order to ensure that the physical characteristics of the work environment do not have a detrimental effect on engagement, productivity and wellbeing."

PHE recommended involving staff in workplace design, something that was done during the stakeholder consultation period for the new ED/CAU.

3.2.3.1. Survey Monkey – May 2021

In May 2021, following the opening of the new ED/CAU in March 2021, a Survey Monkey was carried out to ask staff working within Children's Services, including CBU1 staff working within Children's ED, what they thought of the new CAU facilities and the interface between ED and CAU. 45 responses to the survey were received.

Staff were asked what they thought was working well in the new unit. Their answers are summarised below:

Theme	Responses
Collaborative working between ED/CAU	28
Environment good	20
Medical staff presence	4
Good co-ordinator process	3
Patients and carers happy	2
Enthusiastic attitudes	1
Nothing positive	2

The main positives expressed were around collaborative working between ED and CAU and the environment within the new unit.

The survey also asked staff to identify any particular issues or difficulties they had experienced in the new CAU. Their responses are summarised below:

Theme	Responses
Cramped and noisy space (esp desk area)	22
Lack of confidential space	16
Impact of long ED waits on CAU	12
Lack of handover space	10
Confusion in referral process/responsibility	9
Cubicles too small / too cold / too warm	9
Lack of screen/nurses' station CAU - monitoring difficult	8
Lack of lockers and jnr doctor office space	7
Equipment issues (computers, dictation, stock, IVAC)	7
Social distancing issues	7
Lack of complete co-ordinator rota	5
Communication between co-ords & medics	5
Planned attenders (jaundice, CP medicals)	4
Referral process from ED	3
Repetitive documentation	3
Medical staffing rota / cross cover from ward/NNU	3
Nurse staffing levels	2
Late ward round creating delays in reviews	2
CAU too far from ward	1
Lack of confidentiality (patient whiteboard visible)	1
Poor staff morale	1
Medics leaving CAU during shift	1

The main issues were around the environment (space, equipment) and the impact on CAU of long waits in the ED department.

Staff were asked how they proposed the identified issues could be overcome. A wide range of answers were given. The most popular suggestions for improvement were to create dedicated areas for junior doctor facility, handover and confidential discussions, to clarify the referral process/flow from ED to CAU and to have a clear escalation process regarding assistance in ED.

Following feedback from staff the Associate Director of Nursing, Service Manager, Lead Nurse and lead Consultant Paediatrician met with the Estates team to look at how utilisation of the clinical space could be improved. The Lead Nurse has decluttered storage rooms outside of the department to allow unused equipment to be stored elsewhere and for staff to have safe storage for personal items in lockers. Additional work spaces are to be established with storage to encourage utilisation of the CAU area as a base to reduce staff working at the main ED station. These actions will be completed in the next three months.

In addition, a service wide escalation policy has been developed and this is available on the Trust Approved Documents intranet page. Staff are required

to sign to say they have read it and continued awareness is monitored through regular reviews.

3.2.3.2. Peer review – June 2022

In June 2022, BHNFT Children's Services invited colleagues from Rotherham Hospital NHS Foundation Trust (TRFT) to undertake an independent peer review of Children's services including Children's ED and Assessment Unit, Neonatal unit and the Children's Ward. A self-assessment review had been carried out in line with CQC standards and a rating of "Good" had been allocated. Following the visit, TRFT validated this score and also identified a number of areas where they would deem services as "Outstanding".

These areas were:

- staff engagement
- strong nursing leadership
- robust CAMHS pathway
- early help navigator service
- BLISS accreditation
- robust service improvement plans with excellent assurance and governance arrangements

With this assurance, Children's Services at BHNFT are now embarking on the journey to achieve "Outstanding" across the board.

3.2.3.3. Survey Monkey - July 2022

In July 2022, a further Survey Monkey was started to ask staff working in ED/CAU what they thought of the new provision. The results of this survey will be added to further iterations of this paper ready for Trust Board.

3.2.4. Improved environment within Children's ED and CAU

3.2.4.1. PLACE Inspections

PLACE inspections were paused during the Covid-19 pandemic and are scheduled to resume during 2022/23. The most recent PLACE inspections were carried out in 2019 and were done in relation to the whole Emergency Department, including the Children's area, and for the Children's Ward including CAU. It has not been possible to isolate results for the Children's ED in particular but review of the outcome of the PLACE inspection for the Children's Ward and CAU showed that the main concerns raised were in relation to the poor condition of the area. By building the new CAU and refurbishing Ward 14 to provide bespoke facilities for the Children's Ward it would seem reasonable to assume that these concerns would have been addressed. Confirmation of this will hopefully be received at the next PLACE inspection.

3.2.4.2. Consultation with Stakeholders

Design of the new co-located ED/CAU was done under consultation with a range of stakeholders including staff and Children, Young People and their families via a series of stakeholder events as well as wider consultation on specific issues such as artwork and naming of the new ED/CAU via Facebook polls. Feedback from the stakeholder events highlighted a number of features that participants were keen to see reflected in the new designs. Key elements included:

- Modern, calming environment with individual bright colour schemes or themes for bed bays and cubicles with continuity of design and Visualite panels
    - The colour scheme chosen for the unit is modern and calming with brighter elements being included such as colour blocks on some walls and brightly coloured chairs
    - Colour was chosen, rather than a theme, to identity and individualise the bed bays and cubicles in ED/CAU
    - Each cubicle also has a unique mural on the wall
    - Visualite panels were placed in the treatment room and children's play area
    - Artwork on the walls reflects those used on the new Children's ward
- A separate teenage waiting area and charging points for phones and gadgets
    - A separate teen waiting room was provided with sofas and a TV as well as charging points
- Comfortable facilities for parents, including breastfeeding facility
    - Sofas and a kitchenette were provided in the parents' room and there is a separate breastfeeding room

3.2.4.3. Survey Monkey – July 2022

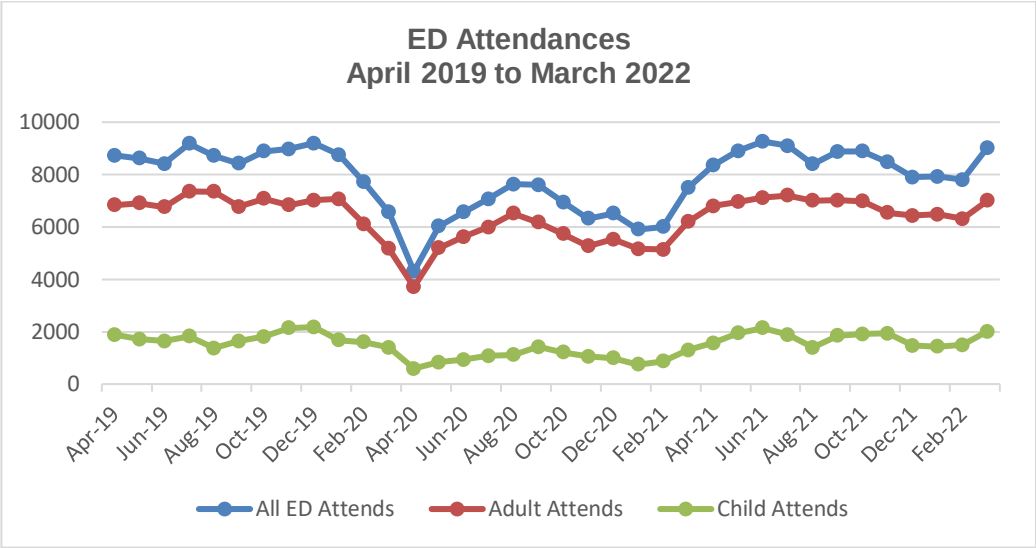
In addition, as mentioned above further Survey Monkey questionnaires have started in July 2022, asking users of ED/CAU what they thought of the new facilities.

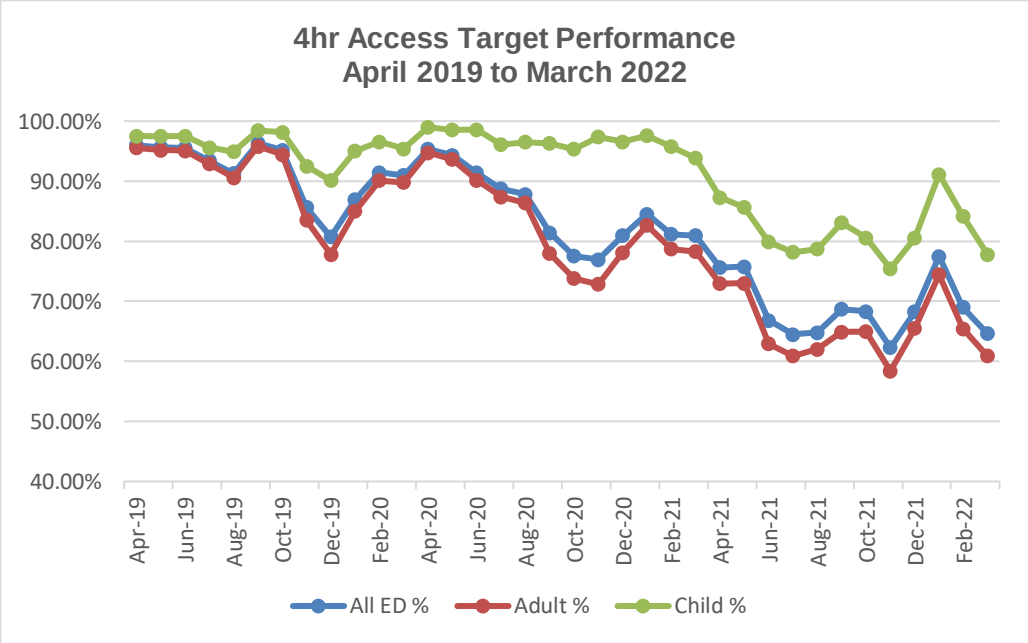
3.2.5. Improved resilience within Children's ED by streaming appropriate patients to CAU

3.2.5.1. Children's ED Attendances and 4hr Access Target

Following the start of the Covid-19 pandemic in 2020/21, there was a gradual decline in achievement of the 4-hour access target for both adult and children's ED. Attendances also declined during the two lockdown periods before seeing a gradual rise back to pre-Covid-19 levels from March 2021 onwards. More recently, monthly Children's ED attendances have been slightly lower than seen during the corresponding period in 2019/20.

The charts below compare performance over the last 12 months for Adult and Children's ED as well as showing the attendance trends for each.





Although performance for Children's ED remains below the required 95% access target at an average of 82% during 2021/22, this is significantly better than the 69% achieved within the adult ED area for the same time period, in spite of increasing attendances during the year.

3.2.5.2. Repeat Attenders to Children's ED

It had been anticipated that enhancement of the CCN team offering, extending service hours to 12 hours a day over 7 days a week, would positively impact on the number of repeat attenders to Children's ED for the same condition. Re-attendances in relation to respiratory conditions, gastrointestinal conditions, mental health issues, allergy and continence problems were felt to be the ones with the most potential for a reduction due to interventions by the CCN team. The following table compares re-attendances for these reasons, within 12 months of the initial attendance, during 2019/20 and during 2021/22.

Reason for Attendance	Re-attendances (%)	
	2019/20	2021/22
Respiratory conditions	770 (26%)	623 (23%)
Mental health issues	71 (22%)	73 (22%)
Allergies	22 (15%)	6 (5%)
Continence	36 (13%)	52 (17%)
Gastrointestinal conditions	19 (12%)	18 (10%)

It had been acknowledged that there was a high re-attendance rate amongst children with respiratory problems and so, one of the objectives of the CCN team development was to increase nurse led asthma and respiratory clinic provision, including the provision of spirometry clinics. This has led to a small reduction in re-attendances for respiratory conditions.

However, the expanded CCN service provision was not established until August 2021 and, although an improvement can be seen for some conditions, as shown in the table above, it is too early to fully assess the impact.

National and local studies have found high demand for ED attendances to be concentrated in areas with greater socioeconomic deprivation, which may reflect a greater healthcare need, a lack of understanding of appropriate services, or a relative lack of primary care services in these areas. (*Socioeconomic deprivation and accident and emergency attendances: cross-sectional analysis of general practices in England; Scantlebury, et al; British Journal of General Practice 2015*). Barnsley is ranked as the 38th most deprived local authority out of the 317 in England. It is therefore important that the service recognises and acts to mitigate the impact that this can have on the volumes of children and families choosing to access the Children's ED in preference to other community-based services.

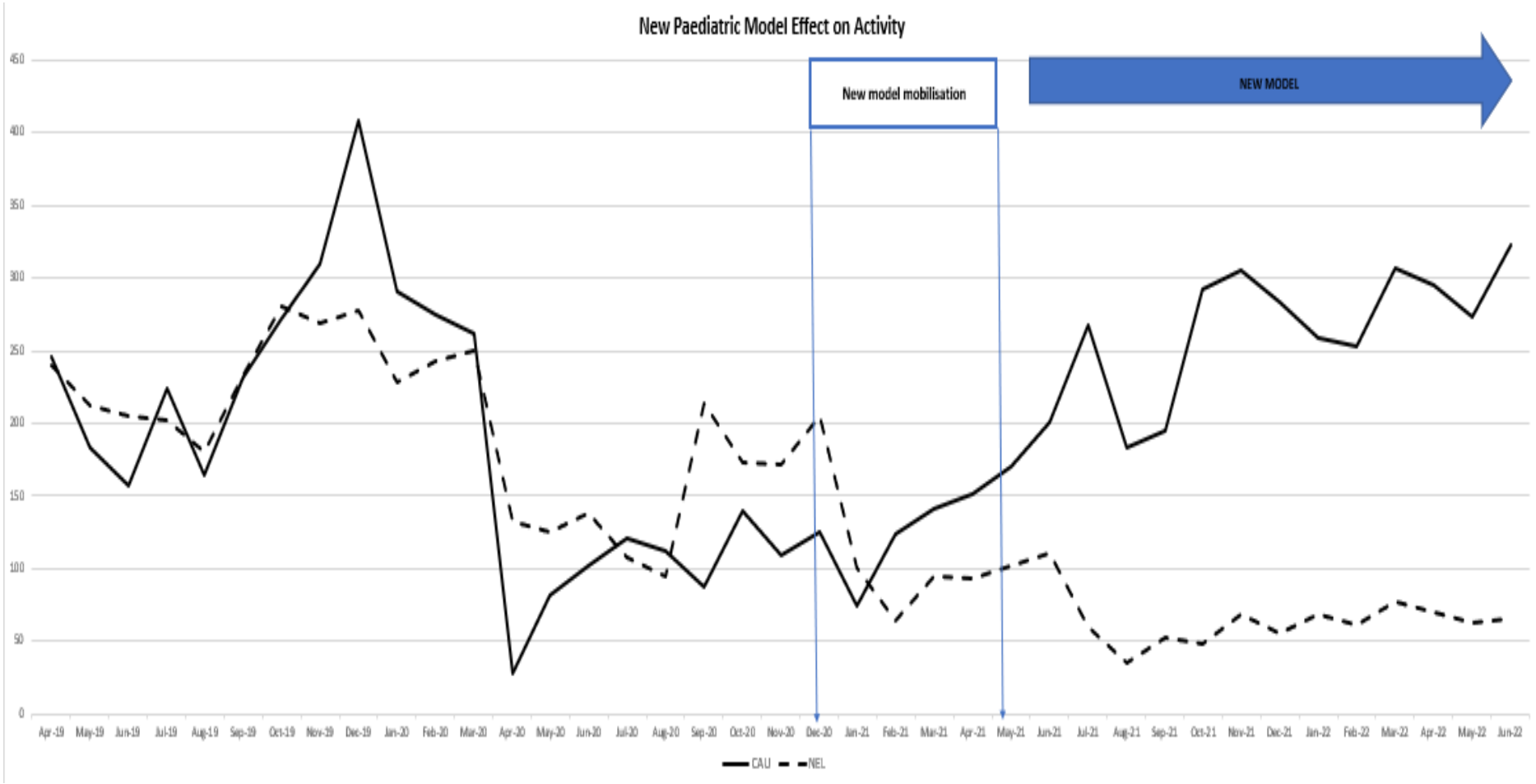
The Lead Nurse within the Children's ED reviews frequent attenders alongside the Early Help Navigator. If there is a need for additional support, an early help referral is completed for support from community services in order to prevent repeat ED attendances longer term. Due the implementation of the early help navigator role it has been possible to support families to engage with community services to address their family's needs preventing repeat attendances. Having the navigator on site has also helped to build understanding between staff of services available in the community which improves referral rates and prevents delay for families seeking support. It also helps to improve community and primary care understanding of the processes in the hospital. Further work is needed to understand the reason for re-attendance amongst this cohort of patients and the other groups above in order to further improve the CCN offer to meet their needs.

3.2.6. Specialty able to manage within new, reduced bed base by streaming appropriate patients to CAU and CCN team

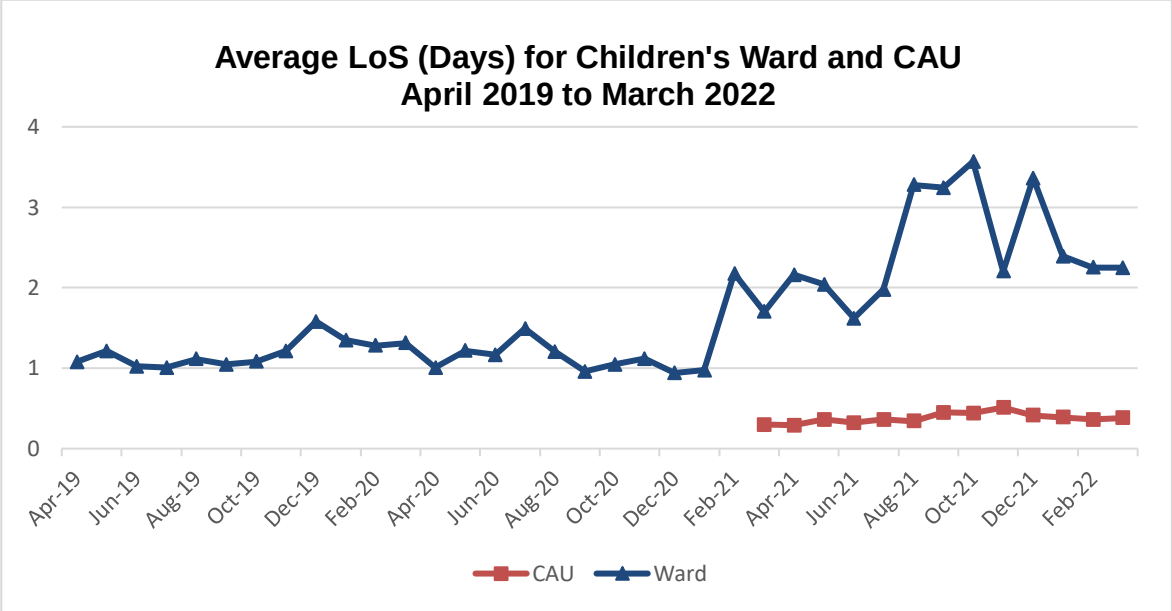
Activity data for the Children's Ward and CAU for the three-year period from 2019/20 to 2021/22 shows a marked shift in admissions from the Children's Ward to CAU, as demonstrated by the chart below.

The new service model working across Children's services allows the team to manage activity according to patient need. This, in the main, reflects the higher activity rates on CAU as the ward have remained with a bed base of eight, except for a handful of occasions where bed numbers have been flexed to support peaks in SY&B demand.

The expanded CCN team became established in summer 2021, with increased capacity to see children outside of the hospital setting and increasing opportunities for early discharge with community support. The impact of this in terms of the volume of community contacts is currently under review due to a lack of granularity in recording of activity.


New Paediatric Model Effect on Activity
New model mobilisation
NEW MODEL
450
400
350
300
250
200
150
100
50
0
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22
CAU
NEL

The chart below shows average length of stay over the last three years on the Children's ward as well as CAU average length of stay since the opening of the new unit in March 2021.



In 2019/20 average ward length of stay was 1.2 days. Since the new CAU opened in March 2021 and started accommodating short stay admissions, avoiding unnecessary admissions to the ward, not only has the number of ward admissions reduced, as shown above and below, but ward length of stay has increased to an average of 2.5 days during 2021/22, demonstrating the impact of the new CAU on the appropriateness of ward admissions. This is summarised in the table below:

Area	Year	Admissions / Attendances	Average Length of Stay (days)
Children's Ward	2019/20	3437	1.2
	2020/21	1971	1.2
	2021/22	1032	2.5
CAU	2019/20	3062	N/A
	2020/21	1848	N/A
	2021/22	4731	0.4

3.2.7. Provision of an In-Reach Service

The CCN team attend ward rounds daily on both the Children's Ward and CAU to encourage referrals into the service and to increase knowledge of the pathways on offer. They also walk around each clinical area to increase awareness and to engage with clinical staff. The CCN team also work in liaison with the College Tutor to ensure compliance with referrals and awareness of the remit of the service amongst medical staff.

In addition, CCNs attend Children's ED to identify and discuss patients

currently in the department to ascertain if any of them can be discharged direct from ED with CCN follow up rather than being transferred to CAU.

3.2.8. Provision of an IV Antibiotic Community Service

The CCN team currently support the administration of IV antibiotics at home for children with complex needs. From June 2021 when the service began to March 2022, a total of 288 visits have been made to children discharged home with CCN support for IV antibiotics when they would otherwise have remained on the Children's ward. This has resulted in a reduced average length of stay for children having IV administration at BHNFT and a more positive patient and family experience. It should be noted that the table below shows all IV administrations, not just antibiotics, as depth of coding does not allow for the isolation of antibiotic administration, though it is thought that the majority of IV administration will be antibiotics.

In addition, the limitations of the service should be taken into consideration when reviewing the data. Currently the team provide a service from 08.00 to 20.00, which prevents them from supporting with IVs at home for patients requiring more than twice daily doses. As a consequence, where the numbers of patients requiring IV treatment has increased, the length of stay on the ward does not fully reflect the expansion of the service. The CCN team are now working towards addressing this with commissioning colleagues with the aim of expanding the working hours and improving early discharge rates.

Area	Year	IV Administration	Average Length of Stay (days)
Children's Ward	2019/20	19	2.74
	2020/21	35	1.20
	2021/22	28	1.43
CAU	2019/20	0	-
	2020/21	16	0.06
	2021/22	36	0.22

Currently, this commissioned pathway only includes children with complex needs. However, over the winter period, the team supported with expedited discharge for acute IV patients and are now utilising data from this exercise to develop a full community IV antibiotic pathway. This may require additional resource to extend the working hours of the service in order to support patients on multiple doses of antibiotics. The demand for this is being assessed and will enable the team to work with colleagues in commissioning to review this as a potential additional pathway for the service.

3.2.9. Participation and Alignment with Multi-Agency Provider Priorities

BHNFT have engaged with Barnsley CCG to review pathways across Children's Services which has included participation in a number of stakeholder working groups which have included representation from

SWTPFT, Barnsley Primary Care Network, education, local authority and regional stakeholders. This ensures the BHNFT is able to develop services in alignment to the strategic intent of local partners in relation to Children's Services. These pathways have included Children's continence services, mental health and well-being and new born blood spots service.

3.2.10. Increase Awareness in Schools, Nurseries and Private Agencies regarding Continuing Health Needs

This was historically done by the generic CCN team, but in July 2021 funding was secured from Barnsley CCG in support of a fixed term, part-time post to provide individualised child-specific training to schools, nurseries and carers. This training is focused predominantly on enteral feeding such as PEGs and nasogastric feeds but also includes catheter care, tracheostomy training and EpiPen training for nurseries and pre-school settings and carers. The gastrostomy feed training is delivered to a small group, each requiring approximately three to four visits for observation and demonstration. A short demonstration video has been introduced in order to reduce the time required per visit.

Whilst delivering the service, the post holder has supported the development of a business case to establish a full service to deliver training across the Barnsley area in the future. See Section 5.0 Future Benefits/Developments for details about the future plans for training provision, including submission of the business case to commissioners.

3.3. Additional Unplanned Benefits

In addition to the planned developments in Children's Services which resulted in the benefits described above, the following have also been achieved:

3.3.1. Advanced Nurse Practitioners (ANP) within ED setting

The ANP roles were already well established within Children's Services and, in order to enhance the resilience of Children's ED in terms of responding to a high level of demand post-Covid-19, ANPs have been allocated to work alongside medical staff in Children's ED rather than increasing the medical staff resource. Prior to this change, the only way to increase resource was to divert Paediatric medical staff from the ward and CAU, depleting cover in those areas and creating bottlenecks further along the pathway. The aim of introducing the ANPs was to reduce the waiting time for patients and improve the 4 hour access target performance.

The ANPs worked from 07:00 to 19:30, Monday to Friday and the initiative was recorded as a Quality Improvement (QI) project. In February 2022, non-recurrent funding was allocated to allow an Emergency Nurse Practitioner (ENP) in addition to the ANPs in Children's ED. The ENP works over 7 days from 09:30 to 22:00, seeing children attending with minor injuries.

Having the ANPs working in Children's ED reduced the waiting time to see a doctor in both Children's and Adults ED and improved the 4hour access target performance in Children's ED from 78% in March 2022 to 90% in July 2022. A business case is currently being developed to fund 24/7 ANPs and 12/7 ENPs in Children's ED.

3.3.2. ANP Clinics

Prior to the opening of the new ED/CAU, children diagnosed with Henoch Schönlein purpura (HSP) and prolonged jaundice would have been reviewed by medical staff on CAU. It has now been possible to develop weekly ANP-led clinics for these children, relieving pressure on CAU and ensuring patients are seen in the most appropriate setting.

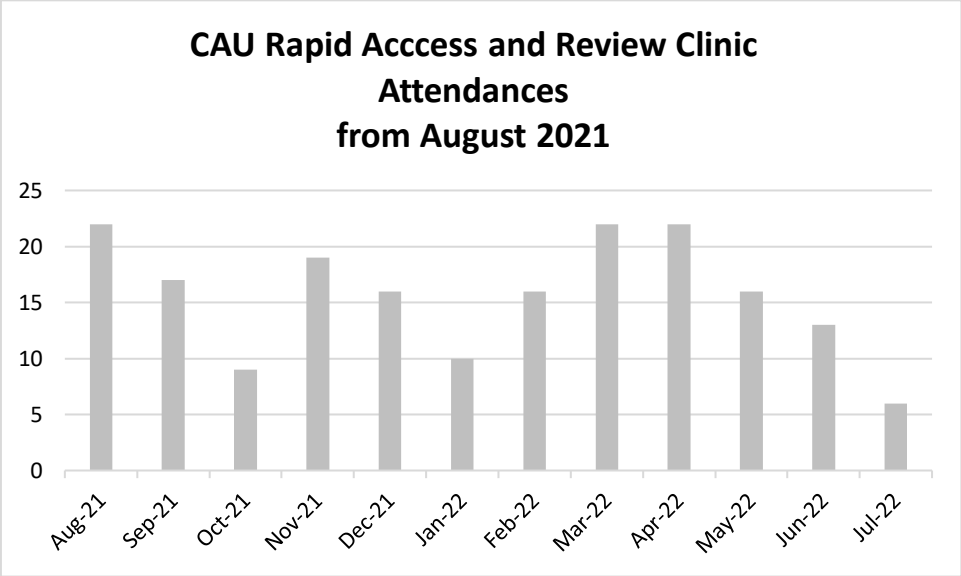
3.3.3. CAU Rapid Access and Review Clinic

It is a CQC requirement that a daily 'hot' clinic should be provided for urgent reviews. CAU has an allocated four time slots per day to provide capacity for review of patients whom the paediatricians require to be seen within 24 hours. These could include long term patients, children with complex needs, children recently discharged from the ward or CAU and children under the care of the CCN team.

The establishment of this pathway has improved access for families whilst negating the need to be readmitted to the ward or CAU or be seen in a routine out-patient clinic. This also creates efficiencies within the Children's outpatient department by freeing up capacity to support with the post-Covid-19 recovery programme.

Families who attend have an improved experience as their wait to be seen is minimised and the team are able to offer reassurance about the child's condition, thus preventing reattendances at ED or our community partners (GP's, 0-19 service or NHS 111) for support.

Since commencement of this service in August 2021, a total of 188 children have been seen in this clinic, as shown in the chart below:



3.3.4. Children's Phlebotomy Service

The children's phlebotomy service has been established for some time, however, other changes to children's services has facilitated a review of this service in order to improve patient experience and access for primary care services. As a result, the service is now part of ERS (Electronic Referral Service, formerly Choose & Book) and GPs can book electronically preventing the need for phone calls and allowing them to choose an appointment date and time which is suitable for the family. This improves attendance rates which then has a positive impact on outcomes via electronic availability of results, allowing GPs to provide treatment to address the child's condition in a timely manner, preventing further deterioration. It also facilitates more timely referrals on to appropriate services where necessary.

The phlebotomy clinic has ringfenced slots for acute patients which reduces the impact on the front door and the ward as these patients would usually attend CAU for expedited access to testing.

Maternity colleagues utilise the phlebotomy service for babies requiring bilirubin (SBR) testing for potential jaundice. For new mums who have recently given birth, being given a set time for attendance and not having to wait allows them to plan attendance around feeding and home life for other children they may have, as well as limiting their physical discomfort if they have experienced a difficult labour.

3.3.5. Child and Adolescent Mental Health Service (CAMHS) / Eating Disorder Pathway

Nationally there has been an increase in access to healthcare by children and young people with emotional and mental health and well-being needs. In Barnsley, there has been an increase in attendances to ED for these young people who often have very complex needs. For those that have been receiving care in the community, an acute attendance can often result in long waits in ED and may then require a referral to paediatrics for specialist input.

The BHNFT team have worked with colleagues at South West Yorkshire Partnership NHS Foundation Trust (SWYFT) to develop a direct access pathway to CAU, diverting attendances away from ED and directly to paediatrics. Community colleagues are able to liaise with the patient flow coordinators and arrange attendance, sharing information about their concerns which prevents the young person and family having to repeat their medical history to another professional. It also allows for the young person to have a timely review with discharge where appropriate and information sharing to community services where care can recommence.

A shared recording pathway has also been developed, allowing for improved information sharing. The implementation of this pathway has reduced escalations of concerns between the services and has resulted in improved patient experience. We have also received national recognition for this with this pathway being requested and shared with numerous other NHS Trusts.

3.3.6. DMSA Scanning

DMSA scanning is used to assess the function and location of the kidneys. It is also used to show any potentially scarred areas in the kidneys, which may not be working as well as they should. It works by injecting a substance called an isotope into the veins, which is then absorbed by the kidneys. The scan is named after the chemical ‘de mercapto succinic acid’ or DMSA for short, to which the isotope is attached.

Previously a paediatric doctor would have to be made available to attend the scanning department for a prolonged period of time to carry out cannulation. DSMA patients now go to the Nuclear Medicine department where the ANP and playleader are able to carry out the cannulation meaning a reduced impact on the medical service and improved patient experience.

4. Finances

In August 2020, a final business case in respect of investment required to ensure safe staffing of the new ED/CAU and Children's Ward was submitted requesting investment of £162k in order to:

- Recruit 1.5wte additional Specialty Doctors to provide dedicated overnight cover on both CAU and the Children's Ward
- Uplift 2.5wte LAS higher doctors to Specialty Doctor to enhance capacity for senior medical decision making, potentially avoiding inappropriate admissions
- Split the staffing for the Children's Ward and CAU, ensuring appropriate cover for each area
- Complete recruitment to remaining Patient Flow Co-ordinator posts
- Develop existing CCN team into Children's Complex and Acute Care Team
- Enhance Ward Clerk support to new CAU

The table below, extracted from the above paper, summarises the requirements in terms of whole time equivalent (wte) and £000's, outlining where funds were already available for reallocation, as well as providing an overview of the current situation as at June 2022.

ED/CAU Investment Required	Final ED/CAU Staffing Business Case - August 2020				June 2022	
	WTE Investment+/ Divestment-	£000's Investment+/ Divestment-	£000's Previously Approved Schemes	£000's Final Investment+/ Divestment-	£000's Investment+/ Divestment-	£000's Variance
Medical Staff	1.50	230		230	157	-73[1]
Med Staff Agency	0.00	-57		-57	0	57[2]
Ward Staffing	-20.81	-987		-987	-952	35[3]
Patient Flow Co-ordinators	5.30	280	-185	95	95	0
CAU Staffing	17.53	717		717	717	0
CCN Team	1.96	118		118	106	-12[4]
Ward Clerks	2.33	64		64	64	0
Non-Pay	0.00	-18		-18	-18	0
Total	**7.81**	**346**	**-185**	**162**	**169**	7

The table below shows the 2019/20 activity and income (for all commissioners), including a restated version with tariff inflation applied for comparability purposes, compared to the 2022/23 plan, following the introduction of the new service model. Through a commissioner lens, there is a clear reduction in inpatient admissions and associated charge, offset by the increase in CAU and community paediatrics cost. This results in a net QIPP (Quality, Innovation, Productivity and Prevention) benefit to the commissioners as a result of the pathway changes.

Trustwide	2019/20 M11R2 FOT (SLAM)		2019/20 at uplifted rate to 22/23		2022/23 Plan		2022/23 Vs 2019/20	
	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
Paediatric Admissions (NELS)	3,896	£3,637,401	3,896	£3,848,370	1,951	£2,647,477	-1,945	-£1,200,892
CAU	3,024	£1,998,081	3,024	£2,113,970	3,121	£2,793,546	97	£679,576
Community Paediatrics	0	£1,669,624	0	£1,766,463		£2,129,239	0	£362,776
Total	**6,920**	**£7,305,106**	**6,920**	**£7,728,802**	**5,072**	**£7,570,263**	**-1,848**	**-£158,540**

4.1. Summary of Deviations

Deviations from the financial plan as outlined above were as follows

- 1.0wte specialty doctor recruited rather than 1.5wte[1]
- On-going medical agency expenditure due to rota gaps[2]
- Children's ward over-established by 0.97wte; reduction of wte in line with budget to be achieved through natural wastage[3]
- Jaundice specialist nurse role not recruited to; clinics facilitated via existing ANP resource[4]

Once the over-establishment on the Children's Ward is resolved, the financial plan will have been delivered approximately £28k under the planned budget.

5. Future Benefits/Developments

Following on from the work carried out to date in relation to the development of Children's Services at BHNFT, a number of further initiatives are underway or planned:

5.1. Continue to work with South Yorkshire Integrated Care System (SY ICS) regarding the CCN service and pathways

The establishment of a seven-day CCN service has led to an improvement in the provision of care for children across Barnsley, not just those with additional or complex needs, as demonstrated in previous sections. The ongoing review of this service, and the positive relationships built with colleagues in commissioning, have facilitated the development of further pathways which will add to the potential for an increase in the care for patients at home, avoiding hospital attendances and admissions.

Pathways and elements of the service which require further work include:

- Acute IV antibiotic pathway
- Home phototherapy pathway
- Dehydration pathway
- Wound care pathway
- Awareness training to schools, nurseries and private agencies regarding Continuing Health Needs

This will also make BHNFT equitable with other Children's services across the SY ICS who already provide community service for IV's, home phototherapy and wound care.

5.2. Undertake a Service Review within Community Paediatrics

A full, service review is planned of the Community Paediatric service, based at New Street Health Centre in Barnsley Town Centre, in order to fully understand the patient portfolio of this service. This will ensure that patients under the care of Community Paediatrics are able to access the expanding services being developed as a result of the changes to Children's services at BHNFT including CCN, CAU rapid reviews and continence services once fully developed. It will also ensure that children and young people are seen in the right place, at the right time and by the right team.

5.3. Other Developments and Initiatives

Other developments and initiatives which are underway or under consideration within Children's Services include:

- Process mapping sessions for sub-specialty areas to assess scope for efficiencies and improvements to patient care
- Working with colleagues in SWYPFT to improve Child and Adolescent Mental Health Service pathway and service provision
- Review of Paediatric Diabetes Service workforce and service provision to ensure compliance with Best Practice Tariff and NICE standards

6. Conclusion

This paper provides an overview of the benefits realised as a result of the developments encompassed within the following three projects:

- Children's In-Patient Ward Relocation and Reconfiguration
- Children's Emergency Department and Assessment Unit Development
- Children's Community Nursing Team Development

6.1. Overall Benefits

Key benefits achieved include:

- Significant pathway development leading to a better experience for children and families, focussing on care being provided outside of the hospital setting
- Co-location of Children's ED and CAU leading to more streamlined and seamless pathways for children accessing emergency care
- Environmental improvements to Children's ward, Children's ED and CAU leading to a better experience for children, families and staff, with changes being informed by large scale stakeholder engagement
- Reduction in in-patient bed base, leading to compliance with safe staffing levels

- Reduction in in-patient admissions through establishment of 24/7 CAU, leading to a better experience for children and families due to expedited discharge with appropriate community support

6.2. Additional Unplanned Benefits

A number of unplanned benefits were realised. These include:

- Establishment of an Advanced Nurse Practitioner role within Children's ED, reducing demand on medical staff and facilitating compliance with 4-hr access targets, leading to a better experience for children and families
- Introduction of a Rapid Access and Review Clinic on CAU, reducing ward attenders and ensuring children are seen in a timely manner
- Review of Children's Phlebotomy Service, with electronic booking available to GPs, leading to a more timely and convenient service for children and families
- Collaboration with SWYFT to develop a CAMHS pathway with direct access to CAU, avoiding ED attendance and a more streamlined service to young people and their families

6.3. Deviations from Planned Benefits

Work continues to evaluate and realise the following planned benefits:

- Increase in CCN contacts:
  The CCN team continue to develop and refine their service and processes, seeing children in the community and thus reducing the burden on hospital services and improving patient experience. Further evaluation of this team will be carried out.
- Community IV antibiotic service:
  An IV antibiotic service is currently provided to children with complex needs, reducing length of stay for these children. Work is underway to establish a full community IV antibiotic service to ensure that all children requiring IV antibiotics can receive them at home rather than in a hospital setting.
- Awareness of Continuing Health Needs:
  Discussions are underway with commissioners regarding the training provision to schools, nurseries and other community agencies in terms of children with continuing health needs. A pilot post has been funded and will form the basis of a business case to establish a full training process to ensure awareness of these children and their needs is increased across all settings.
- Supporting the wider ED in achieving the 4-hour access target:
  The co-location of CAU with Children's ED has allowed the team to support initiatives to improve performance across the department, facilitating the timely transfer of patients to CAU when demand is high in ED. The establishment of the ANPs within Children's ED has also shown that on shifts where they are working, the performance rates for Children's ED increase significantly, which impacts the Trust performance compliance.

Appendix 1

Children's ED/CAU Development and Children's Ward Reconfiguration Clinical Pathways

In order to ensure the operational success of the new Children's ED/CAU and Children's ward, it was recognised that it would be necessary to develop a range of clinical pathways. These are listed below along with their current status.

Clinical Pathway	Status – July 2022	
Ambulance > Children's ED	✓	
Walk-ins > Children's ED	✓	
Children's ED > CCN	✓	
Children's ED > Children's HDU	✓	
Children's ED > Children's Ward	✓	
GP > CAU	✓	
OPD > CAU	✓	
CAU > Children's Ward	✓	
CAU > Home/GP/CCN/FU	✓	
Children's Ward > Home/GP/CCN/FU	✓	
Children's OPD > CCN	✓	
CCN Team Referral	✓	
Trauma > Children's Ward	✓	
Electives > Children's Ward	×	In discussion with CBU2
RightCare Barnsley	✓	
DMSA Cannulation	✓	
Heart Murmur	✓	
HSP CMPA/GORD	✓	
Semi Urgent Referrals	✓	
Jobs List (CAU)	✓	
Respiratory Nurse Led	✓	
RAC/CAU Clinic	✓	
Open Door & Open Access	✓	Review and update of pathways underway
Child Protection Medical	✓	Further review being carried out in light of commissioning arrangements
Continence Clinic	✓	Full review of Children's continence service being undertaken by commissioners at BHNFT request. Continence service not formally commissioned from BHNFT though currently provided
Jaundice	×	ANP-led jaundice clinic established Home jaundice pathway to be developed
IV Antibiotics	×	CCN team not commissioned to provide an acute home IV service. Currently under discussion with commissioners.

Break

6. For Information

6.1. Chair’s Report

To Note

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS - Public				REF:	BoD: 23/02/02/6.1
SUBJECT:	**Chair's Report**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	Sheena McDonnell, Chair				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Sheena McDonnell, Chair				

STRATEGIC CONTEXT

To report particular events, meetings publications and decisions that the Chair would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chair since the last meeting and highlight a number of items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

The Board of Directors is asked to receive and note this report.

Subject:	Chair's Report	Ref:	BoD: 23/02/02/6.1

Best for Performance

1.1 Strategic Planning

We held a useful workshop with Governors and board members in December. The workshop was an opportunity to look back at what we have achieved in relation to our strategic plans and an opportunity to look forward to our future and engage our Governors in thinking about those priorities and how they feature in our plans.

1.2 Critical Care Unit

We are developing a new critical care unit at the hospital and Richard, and I were fortunate enough to have a tour of the building prior to its completion and handover. The teams have had a great deal of involvement in designing the new space to enable the best possible care and experience for our patients. The unit will be handed over in the coming month with patients being able to use the facility soon after and we will be holding an official opening event to launch the new facility.

1.3 Community Diagnostic Centre

Following the success of our community diagnostic centre we are now embarking on an extension to the centre which is situated in the Glass Works in the town centre. This will see the model of care closer to the community extended further with more diagnostic testing in the heart of the community.

Best for Patients and the Public

2.1 Member Engagement

We continue to engage more widely with our communities through Andrea Spencer our engagement lead. We have managed to engage effectively with partners such as Chillypep which is a young person's mental health charity who are interested in working more closely with our Governors and being an active voice

2.2 Governor Elections

We still have some vacancies on our Council of Governors so we are currently out to recruit via a public campaign to fill those vacancies. This is managed independently through our election agency UK engage.

2.3 Hospital at Night

I was able to attend the hospital on a Friday evening to get a sense of some of the operational pressures and approach at night which as you can appreciate is very different to the day. Our teams have been under considerable pressure both at the front end of our services through urgent and emergency care and also throughout the hospital with additional wards having been opened to cope with demand as well as the continuing challenge of increasing elective activity to reduce waiting lists.

Best for People

3.1 Volunteers Celebration

I am passionate about supporting and acknowledging the great work that our volunteers do in the hospital. We could not do what we currently do without their valuable contribution. So, I was delighted to be able to join the volunteers for their annual celebration. It was our opportunity to say thank you in a small way to them for their hard work. I was also able to present awards to some of our longest serving volunteers in recognition of their contribution over many years at the Trust. It was also an opportunity to recognise the brilliant work of our volunteer team who arrange for placements and support our volunteer's particularly in creating those enhanced volunteer opportunities.

3.2 New Governors

Following a recruitment campaign last year, we have been able to welcome new Governors to the Council of Governors. We have welcomed a new public Governor in Alan Parker and welcomed back Margaret Sheard for her second term. We have also welcomed two new colleague Governors who represent our clinical and nursing and midwifery teams, Wissam Al Ahmad and Nigel Bullock. We have already hosted an induction programme for our new Governors so that they are able to commence in their role as soon as possible.

3.3 Non-Executive (NED) Recruitment

Following a robust recruitment process we are pleased to have be joined on the Board by David Plotts who was a previous Associate Non Executive and brings a wealth of experience

in the private sector as well as being a local resident. We have also been joined by Gary Francis who in his medical career as an anaesthetist also spent some time at Barnsley hospital as an interim Medical Director. Nahim Ruhi-Khan and Neil Murphy have also joined us as Associate Non-Executives for a period of 12 months.

3.4 Cost of Living Group

This group has been meeting regularly to co-ordinate actions and activity in relation to easing the cost-of-living burden for colleagues and people who use our hospital services. A range of actions have been developed following discussions with colleagues and partners. Barnsley Hospital have been working alongside the council to promote the 'more money in your pocket' website which has a range of resources available.

3.5 Brilliant Awards

I regularly get the opportunity to give out our brilliant awards to our colleagues, individuals and teams who have been nominated by their line managers, peers or the public. This month has been no exception with presentations taking place in maternity which is a regular nominee and is one of the areas which does receive lots of public recognition.

3.6 Barnsley Facilities Services (BFS)

We have been recruiting to the role of managing director for our wholly owned subsidiary Barnsley Facilities Services following the proposed retirement of the current postholder Lorraine Christopher. After an extensive external recruitment approach, we are pleased to appoint Rob McGubbin to the role. Rob has been the Deputy in this role for the past few years and so already has a great understanding of the opportunities and development areas for BFS and we are looking forward to continuing the productive working relationship with BFS and the Trust.

Best for Place

4.1 Place and Partnership Board

This group continues to meet with partners from across health and care systems including primary care, the Voluntary and Community sectors, and the Local Authority. The meetings are held in public and are recorded and questions are invited from members of the public. The most recent meeting considered feedback on the new integrated care strategy mentioned below, performance and funding and assurance from the Mental Health, Learning Disabilities and Autism services, among other items.

4.2 Integrated Care Partnership

The integrated care partnership has been meeting regularly to finalise the strategy for the Integrated care Board. The strategy is in its final iterations now and has been informed by an extensive engagement approach with communities across South Yorkshire exploring what is important in relation to health and wellbeing. The key priorities identified by the public have been access to health and care services and the quality of services among other important areas. There is an easy read version of the strategy and an executive summary which will be promoted in March when final edits are completed.

4.1 Acute Federation

A board development event for all board members from all acute hospitals in the South Yorkshire region was hosted at Hellaby Hall in December. This event was designed to build on the relationships being established across the acute federation and the opportunities that exist to collaborate more across the system to benefit the population of South Yorkshire.

4.2 Bloomberg Harvard

The Mayor of South Yorkshire has been invited to put forward a team to participate in a city leadership programme with Harvard and Bloomberg exploring along with other teams from across the USA and Europe key challenges facing cities. The Mayor has chosen health inequalities with a particular focus on the start of life as the challenge for South Yorkshire. This is of particular importance in Barnsley with the widening and worsening health inequalities and I am delighted to have been invited to be part of the team from South Yorkshire.

Sheena McDonell
Chair
February 2023

6.2. Chief Executive Report

To Note

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/6.2

SUBJECT:	**CHIEF EXECUTIVE'S REPORT**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	Emma Parkes, Director of Marketing & Communications				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

To report particular events, meetings publications and decisions that the Chief Executive would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

The Board of Directors is asked to receive and note this report.

1.0 Operational Update

1.1 During December and January Barnsley Hospital experienced significant operational pressures, as did other Trusts regionally and nationally. Unusually high attendances at the Emergency Department, Strep A, a high prevalence of patients with Covid-19 and Influenza requiring inpatient beds and staff sickness resulted in the Trust opening the winter escalation ward in late December.

1.2 The Trust worked closely with partners at Barnsley Place and the South Yorkshire Integrated Care System (ICS) during this time to maximise bed capacity and to both seek and provide mutual support where necessary.

1.3 Although recently the number of patients in hospital with influenza has reduced significantly, the Trust continues to treat 40-50 Covid-19 positive patients. Mask wearing remains in place in place in the hospital environment for staff, patients and visitors although this remains under close review and will be adjusted depending on the prevalence of Covid within the hospital and the community.

1.4 I would like to record my sincere thanks to colleagues at Barnsley Hospital for their dedication to patient care during this particularly challenging time.

2.0 Elective Recovery Update

2.1 The Trust had to cancel some routine activity to support emergency care pressures during December and January however there remain no patients waiting longer than 104 weeks and just 3 waiting longer than 78 weeks currently. The Trust is within the top quartile nationally for patients waiting less than 52 weeks. It is anticipated that the target of no patients waiting more than 78 weeks by 31st March 2023 will be achieved. The Trust is working with other local partners to provide mutual aid to support reducing waiting times across South Yorkshire.

3.0 Industrial Action

3.1 A number of trade unions representing NHS staff groups are in dispute with the Government over the 2022/23 pay award. Unions have balloted their NHS members to take part in industrial action, some of which has taken place.

3.2 In January, Royal College of Nursing members took industrial action over two days at Barnsley Hospital and there were also a number of episodes of industrial action affecting the Yorkshire Ambulance Service. The Chartered Society of Physiotherapists will be striking for 24 hours on 26th January. Other ballots involving GMB members and the BMA are in progress.

3.3 I would like to thank Becky Hoskins, Deputy Director of Nursing and Emma Lavery, Deputy Director of Workforce and all colleagues who supported the planning and preparation for industrial action and those colleagues who undertook additional or alternative duties during the action to support the Trust. Relationships with Trade Union colleagues in the arrangement of derogations were very constructive.

3.4 In the coming weeks further industrial action is planned however not every hospital and ambulance service will be affected by strike action. We continue to work together with our local union representatives to plan how services will operate during any period of disruption.

3.5 I would like to reassure the public that they should continue to come forward for emergency services as normal during future industrial action. Barnsley Hospital is committed to provide essential services, and to keep disruption in affected services to a minimum.

Best for Patients and the Public

4.0 Investment in Services

4.1 Community Diagnostics

In April 2022, Barnsley Hospital opened the doors to its pioneering Community Diagnostic Centre (CDC) in the town centre's Glass Works. Developed with a capital budget of £2.8m, the unit offers blood tests, DEXA, Ultrasound, X-ray and Breast Screening Services. It is the first of its kind in a town centre retail facility.

Having secured further funding of £4.6m, the hospital is currently in the early stages of the Phase 2 expansion of the CDC with the plan to offer CT and MRI, Urodynamics, ECG and Spirometry and Retinal Screening Services by the end of 2023.

4.2 Intensive Care Unit

I am delighted to report that the hospital's new ICU facility is nearing completion following a £7.3m investment to double the capacity of the current 16 critical care beds to 32. This will help meet current demand pressures as well as help future proof the hospital's care capacity to care for the most poorly patients. We hope to be able to welcome patients from March 2023.

Best for People

5.0 NHS Staff Survey

5.1 The NHS annual staff survey is a key way in which we assess how well we live up to our People Promise, in particular 'We each have a voice that counts.' By understanding their experience of staff and working to improve that experience, we will improve our effectiveness and services.

5.2 The Trust's survey was undertaken by the Picker Institute between October and December 2022; all eligible staff were invited to participate. The Picker response rate for the 2022 staff survey was 59% and this includes Barnsley Facilities Services (BFS) staff. This compares favourably to the average response rate for similar organisations, which was 46%.

5.3 The initial results in the Picker Report have been received and Directorates and CBU leads are working through the data to identify areas that have improved and to develop plans to address improvements that are needed.

5.4 The full set of results are under embargo until the publication of the NHS England Report which is due in early March.

The Trust continues to work with partners locally, regionally and at a national level to deliver a co-ordinated and consistent approach to the effective management of services.

6.0 Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust partnership

6.1 In line with the Joint Chief Executive role and the two independent organisations working more closely together, a joint Strategic Partnership Group meeting was held in January to progress operational priorities and opportunities for 2023/24. A proposed joint work programme will be presented to both Boards in early March.

6.2 From 1st February, Angela Wendzicha will join the Trust as Interim Joint Director of Corporate Affairs for six months, following the departure of Gilbert George. Angela is substantively Director of Corporate Affairs at The Rotherham NHS Foundation Trust. Angela started her career as a nurse before also training in law and is highly experienced in corporate governance. I would like to thank Gilbert for the excellent work he has done over the last three months and wish him well with his new role in Nottingham.

Dr Richard Jenkins
Chief Executive
February 2023

6.3. Intelligence Report

For Assurance

Presented by Emma Parkes

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/02/02/6.3

SUBJECT:	**INTELLIGENCE REPORT**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	
	For information	✓		*Strategy*	✓
PREPARED BY:	Emma Parkes, Director of Communications & Marketing				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Emma Parkes, Director of Communications & Marketing				

STRATEGIC CONTEXT

To provide a brief overview of NHS Choices reviews and ratings together with information on relative key developments, news and initiatives across the national and regional healthcare landscape which may impact or influence the Trust's strategic direction.

EXECUTIVE SUMMARY

Summary of content:

- NHS Feedback Ratings
- Industrial Action Update
- CQC Support NHS Frontline
- New Appointment: National Director: NHS digital channels

RECOMMENDATIONS

The Board of Directors is asked to receive the contents of this report for information.

Subject:	INTELLIGENCE REPORT	Ref:	BoD: 23/02/02/6.3

*please note that this is not an exhaustive report, submissions welcome to emmaparkes1@nhs.net

SUBJECT

Emergency Department – Jan 23 - Great service amongst an NHS crisis - ★★★★★
My son had an allergic reaction to something and I had to take him to Children's A&E. I really cannot fault the service received. Everyone from the receptionist, to the nurses, cleaners and doctors were extremely helpful and always friendly. They made sure my little one had toys to play with in our cubicle, they made sure he got a snack after a long waiting period, offered me something to drink and were very helpful and friendly whenever I saw someone or had questions. I was so grateful to the staff from yesterday.

Emergency Department – Jan 23 - Treatment in ED - ★★★★★
I had a very positive experience when being treated for a broken bone in my foot. I went from triage to nurse practitioner to x Ray to plastering to doctor and OT/Physio very quickly and efficiently. Everyone was friendly professional and explained my treatment at every stage. There was virtually no waiting time after the triage. I was extremely impressed especially after what I had watched on TV. It was the NHS at its best.

Emergency Department – Jan 23 - Going over and above - ★★★★★
My wife attended A & E being brought in by ambulance. Despite an acknowledged significant wait time she was triaged, seen by a consultant and discharged within a couple of hours. The attitude of the nurse who triaged her was exemplary, she was kind and considerate to me and my daughter but more particularly to my wife a 78 year old lady with dementia. Despite the Department being extremely busy she went out of her way to help her, in my opinion over and above what I would have expected. Nothing was too much trouble. I would like to thank her most sincerely.

Emergency Department – Dec 22 - Excellent Care - ★★★★★
Despite the strain of strikes etc etc; my husband received excellent fairly speedy treatment on Monday 19th Dec 2022.Dr in A@E was thorough polite and reassuring. Staff on ward 20 were pleasant its a Big Shout Out For BDG. God Bless our NHS. Thankyou from the bottom of our hearts. Happy Christmas.

Emergency Department – Dec 22 - Horrible service - ★
Booked in Mon, 5th Dec 8.40pm. Booked out Tue, 6th of Dec, 10.50pm. 14 hours at 'emergency' department. Next time, I'll take a bed with me. Thank you, NHS!!!

Emergency Department – Dec 22 - Horrible - ★
Waiting here for more than 6.30 hours. Nurse came to tell us that waiting time is more than 8 hours. And I forgot to clock in! Bring yourself sandwiches and a cuppa! And air con.

Children's & Adolescent Services - Jan 23 - Excellent service - ★★★★★
Excellent service, waiting time is like 2.min. Excellent nurse and a Dr we meet. Explaining us well they finally treated are son well.

Ward 33 - ★★★★★ – Jan 23
What an amazing team on Ward 33. From going through A&E (who were also amazing) to being admitted, Barnsley DGH were outstanding. Nothing too much trouble, I was kept updated constantly with my treatment. Staff were incredible despite being short staffed they

SUBJECT
carried on and did a sterling job. Keep fighting for that pay rise/working conditions. You deserve everything and more. True angels on earth - Thank You!!! **Dentistry and Orthodontics - Dec 22** **A kind, caring, compassionate and truly professional team - ★★★★★** I had two wisdom teeth removed under general anaesthetic and I am a very anxious patient. Every single person that dealt with me from the first consultation to the final discharge was a genuine pleasure to meet. All understood and acknowledged my concerns and all took steps to minimise my concerns, particularly at the times it mattered. Barnsley Hospital staff are clearly dedicated to the jobs they do and I could not have felt any better cared for during my short visit. Thank you all at Barnsley Hospital. **Gastrointestinal and Liver services - Dec 22** **Excellent Care - ★★★★★** I was admitted to Barnsley hospital following a post-surgical issue. At the time the consultant in charge and his team were unsure why I was unable to eat and constantly vomiting. He was very quick to put a logical plan into place where each procedure ruled out the core issues. I had previously been in another hospital who didn't try and make thorough investigation into the problems. I can only thank the whole team all the nurses doctors consultants domestics cleaners the whole team. Even though I was unable to eat for most of the time once I could I can only give brilliant reviews to the selection and presentation of everything I was offered. Thankyou Barnsley hospital for getting me back on my feet in record time you have been amazing, all of you what an incredible team of people.
Planned Industrial Action Trade unions representing some NHS staff are in dispute with the Government over the 2022/23 pay award. A number of the unions have balloted their NHS members to take part in industrial action, some of which has taken place. In the coming weeks more industrial action will take place as follows: • Members of **UNISON (ambulance workers)** are striking on Mon 23 January. • Members of **GMB (ambulance workers)** are striking on Mon 6 and Mon 20 February, and Mon 6 and Mon 20 March. • Members of **Unite (ambulance workers)** are striking on Mon 6, Thu 16, Fri 17, Mon 20, Wed 22, Thur 23 and Fri 24 February, and Mon 6 and Mon 20 March. • Members of the **Chartered Society of Physiotherapy (CSP)** are striking on Thu 26 January, and Thu 9 February. • Members of the **Royal College of Nursing (RCN)** are striking on Mon 6 and Tue 7 February. Not every hospital and ambulance service will be affected by strike action.
Staff at the Care Quality Commission have been released to volunteer for frontline work at trusts during the winter crisis The CQC has said staff with experience working in the NHS can volunteer for a limited time to support providers under severe winter pressures. The move forms part of the CQC's response to the current pressures in the NHS, which also includes suspending some inspections of GP services which had been planned for this winter. If staff with up-to-date clinical qualifications wish to return to frontline services they will be supported to do so if possible. This was also the case during covid, when a small number of clinically qualified staff returned to frontline services, in addition to staff who volunteered in a non-clinical capacity.

SUBJECT
The CQC has said there will be no further changes to its risk based inspection approach during the winter, other than the postponement of some GP inspections. The CQC's will continue to respond to the most serious risks in NHS organisations.
NHS England has hired a hospital CEO to work part time as its national director for digital channels. Milton Keynes University Hospital Trust Chief Executive Professor Joe Harrison has been appointed National Director: NHS digital channels, in addition to his trust CEO role. Health and Social Care Secretary Steve Barclay and NHSE have said in recent months they will prioritise development of new functions in the NHS App. NHS England is carrying out a restructure including merging with NHS Digital, and carrying out a large headcount reduction.

6.4. Barnsley Integrated Care Partnership Group: verbal

To Note

Presented by Sheena McDonnell

6.5. Acute Federation Update including

• South Yorkshire & Bassetlaw (SY&B) Highlight Report

To Note

Presented by Sheena McDonnell and Richard Jenkins

ACUTE FEDERATION BOARD MEETING: 9 JANUARY 2023

SYSTEM DELIVERY GROUP CHAIR'S SUMMARY REPORT – October/November/December 2022

1.0 INTRODUCTION

1.1 This summary paper provides an overview of the significant issues of interest to the Acute Federation Board following the System Delivery Group (SDG) meeting on 21st October 2022, 18th November and 16th Decem2022. It is intended to highlight the main areas of discussion, the key decisions and actions agreed, together with details of any development issues and risks affecting the SDG over the last month.

1.2 The substantive areas of discussion on the agenda included:

- Communications Plan – Progress on Implementation
- Update from the NHSE Provider Collaborative Event – 5 December 2022
- Critical Care Stocktake: Capacity and Demand
- AF Infrastructure
- Provider Collaborative Innovator Forum
- Montagu Orthopaedic Elective Centre
- Skin Cancer Pathway
- Development of a dashboard

1.3 In addition, the meeting received the following update:

- Professional Partnership Groups highlight report

2.0 COMMUNICATION PLAN – PROGRESS UPDATE ON IMPLEMENTATION

2.1 The Group received the updated Communication Plan and noted the contents.

3.0 UPDATE FROM NHSE PROVIDER COLLABORATIVE EVENT

3.1 It was confirmed diary invites have been sent out for the event and the agenda is being progressed with NHS England and CEO's.

4.0 CRITICAL CARE STOCKTAKE: CAPACITY AND DEMAND

A presentation took place from the Critical Care Operational Delivery Network there role as been managing the pandemic with the ICS in more recent times. They have been asked to bring colleagues together in a more structured way and reform some of the arrangements that were previously in place under the ODN and as a result of that, it was agreed in the Federation that these sorts of hosted clinical networks would have a CEO as Lead and RP had agreed to do Critical Care.

The modelling Critical Care through time looks at specifically what our units have now and what they may need in the future, and that includes both the physical bed spaces and the workforce resource, Consultants, Nurses and support services. These regular updates will steer strategic direction.

5.0 ACUTE FEDERATION INFASTRUCTURE

A paper was presented which articulates the resources required by SYBAF to operate as an effective collaborative function between the 5 partner Acute Trusts and to expedite its agreed priorities.

The five Trusts who make up SYBAF recognise the need for SYBAF infrastructure to be funded by Trusts. The level of contribution from each Trust is in accordance with a fair financial distribution model agreed through Directors of Finance PPG.

It was agreed to produce a version that the CEO had before with the specific costs against the infrastructure and delivery, so it mirrors a business case and then separate to that the discussion around the split and distribution.

6.0 PROVIDER COLLABORATIVE INNOVATOR FORUM

NHSE wrote to system leaders in both Integrated Care Boards and Providers 9th November describing a new programme to accelerate the development of Provider Collaboratives (PCs).

The context for this is to underpin the intent within the Health Care Act 2022. Rather than just re-shape commissioning organisations, the proposed removal of PbR and the development of providers working at scale in a more formal way is intended to help behaviours change and encourage more collaborative solutions to deeply entrenched variation in quality and sustainability of services. This aim of this programme is to take a cohort of nine Provider Collaboratives and increase the pace of their development.

The process is being led by the NHSE Policy team and supported by Regional Teams. SYBAF have good relations with NHSE Policy team following engagement with PC governance and infrastructure discussions prior to the national guidance.

An expression of interest has been submitted to the national programme, there had been a paper from NHS England for 9 provider collaboratives to be identified nationally and then they would be part of a development programme going forward.

7.0 MONTAGU ORTHOPAEDIC ELECTIVE CENTRE

A presentation was given on the Montagu Orthopaedic Elective Centre business case.

8.0 SKIN CANCER PATHWAY

The Skin Cancer Pathway requesting the group approve the implementation for a solution for sharing images of skin lesions in South Yorkshire was presented. Future costs are currently being sought before approval.

9.0 DEVELOPMENT OF A DASHBOARD

A paper was presented following an offer of support from the ICB to develop a high level dashboard for a key set of performance metrics for the Acute Federation and also at the board to show our aggregate position as well as the contribution that each organisation makes to that.

10.0 RISKS

10.1 The group discussed the letters being received by staff regarding the pension tax and the potential risks within the system following these letters. It was agreed further information will be shared as it becomes available.

11.0 DELEGATION AND ESCALATIONS

11.1 It was confirmed that there were no issues or matters of concern identified at the meeting for escalation to the Federation Board.

120 RECOMMENDATIONS

12.1 The Board is asked to receive and note this summary report.

Ruth Brown
Acute Federation Lead Chief Executive and Chair of the System Delivery Group
3 JANUARY 2023

6.6. Integrated Care Board Update including:

• Place Board Committees Terms of Reference - Wendy Lowder - Executive Place Director of Place Health and Adult Social Care in attendance

To Note

Presented by Richard Jenkins and Bob Kirton

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/02/02/6.6

SUBJECT:	**BARNSLEY PLACE NEW GOVERNANCE ARRANGEMENTS**				
DATE:	2 February 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	✓
PREPARED BY:	Barnsley Place Team				
SPONSORED BY:	Sheena McDonnell, Chair Richard Jenkins, Chief Executive				
PRESENTED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive				

STRATEGIC CONTEXT

We will fulfil our ambition to be at the heart of the Barnsley Place Partnership to improve patient services, support a reduction in health inequalities and improve population health.

We will work with partners within South Yorkshire ICS to deliver improved and integrated pathways. We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health.

This links to risk 2527: Risk of failure to develop effective partnerships

EXECUTIVE SUMMARY

Partners in Barnsley have come together as the Barnsley Partnership Board to enable the delivery of integrated population health and care services in Barnsley. Included in this report are the refreshed Barnsley place agreement, TOR for place partnership and TOR for the new subcommittees.

Place Agreement (see Appendix 1)

The Barnsley Place Agreement provides an overarching framework for the continued development of a place-based partnership for Barnsley. The arrangements set out are intended to build on the existing integrated governance structures between the health and care partners in Barnsley, and further strengthen relationships between the Partners for the benefit of the Barnsley population. This final version of the agreement was presented at the Place Board in October 22 and reviewed by all partners.

Terms of Reference for the Partnership Board (see Appendix 2)

Barnsley Place Partnership Board –meeting to carry out **Partnership Business** i.e. aligning decisions on strategic policy matters made by Place Partners that are relevant to the achievement of the Barnsley Place Plan.

- *In this role the Partnership has no delegated decision-making powers but it can make recommendations back to sovereign organisations, or individuals from partner*

organisations may have personal delegated authority from their organisations.

Barnsley ICB Place Committee - established as a committee of the ICB Board, in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation & Delegation, to undertake **ICB Business**.

- *When the Partnership Board sits as the ICB Place Committee it has delegated authority from the ICB Board to make decisions about the use of ICB resources in Barnsley in line with its remit, and otherwise support the ICB.*

In accordance with the Board's dual role described above these Terms of Reference include sections dealing with both the operation of the Board when meeting as the Barnsley Place Committee to carry out ICB business (these terms of reference were approved by the ICB at its first meeting in July 2022 and can only be subsequently amended by the ICB), and also the operation of the Board when carrying out Partnership business (these terms of reference are able to be amended by the Board).

Sub committees and sub groups of the Place Partnership Board (see appendix 3)

The authority to establish working groups, which is set out in the Partnership's Terms of Reference, differs depending on whether the Partnership Board is meeting as the Place Committee to do ICB Business, or the Place Partnership to do Partnership Business, as follows:

At its meeting on 28 July 2022 the Place Partnership Board approved a draft governance structure for the Partnership outlining the sub committees and Sub Groups it wished to create. These were:

Sub Committees of the Barnsley ICB Place Committee:

- *ICB Senior Management Team*

SMT operates as a joint working group to enable the ICB Executive Place Director / Executive Director Adults & Communities effectively to discharge her responsibilities by coordinating the work of senior managers across health and adult social care, enabling them to work effectively together as a forum for the exchange of ideas and for identifying opportunities for collaboration and integrated working. This is for information.

Sub Groups of the Barnsley Place Partnership:

- *Place Partnership Delivery Group*

The purpose of the PPDG is to oversee and deliver the ICP priority programmes as agreed within Barnsley health and care plan and also overseeing delivery of the ICP development plan.

- *Place Partnership Finance, Performance, & Efficiency Group*

Operationally responsible for the conduct and delivery of matters of the Barnsley Partnership Board developing a plan for financial sustainability and supporting delivery of the health plan and place/ICB strategy.

- *Place Partnership Quality & Safety Sub Committee*

QSC is responsible for monitoring and improving the quality and safety of all services commissioned by SY ICB and being delivered in Barnsley or directly commissioned for Barnsley residents.

- *Place Partnership Involvement & Equality Group*

BIEG is responsible for the development, delivery and oversight of the Barnsley health and care people, carers and community's involvement and equality plan.

Next steps

This report is being shared with partner organisations so that they can take the final documents through their internal governance routes for information and review. All the Terms of Reference will be subject to early review in March / April 2023 when partners will have the opportunity to make any amendments necessary once this structure has been operational for a few months.

Issues for further Consideration

- Further clarity is required re reporting arrangements for provider collaboratives (currently to SY ICB only)
- Further discussion required section 13.2 of the partnership agreement on risk share.
- Further clarity on areas marked as requiring more work including clinical engagement and joint commissioning on the draft governance structure.

RECOMMENDATION

The Board of Directors is asked to approve the key governance documents underpinning the Barnsley Place Partnership, specifically the:

- Place Agreement
- Place Partnership Board Terms of Reference, and the
- Terms of Reference for the Barnsley Place Partnership Board's Sub Committees and Sub Groups.
- Note and discuss the issues for further consideration.

BARNSLEY PLACE AGREEMENT

DATE **24 October** **2022**

1. NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD

2. BARNSLEY METROPOLITAN BOROUGH COUNCIL

3. BARNSLEY HOSPITAL NHS FOUNDATION TRUST

4. SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

5. BARNSLEY HEALTHCARE FEDERATION

6. BARNSLEY HOSPICE

7. BARNSLEY COMMUNITY AND VOLUNTARY SERVICES

BARNSLEY PLACE AGREEMENT

FOR THE BARNSLEY PLACE PARTNERSHIP

No	Date	Version Number	Author
1	09.03.21	1	Hill Dickinson
2	29.03.21	2	Hill Dickinson – following Design Team meetings 11.03.21 / 23.03.21
3	12.04.21	3	Hill Dickinson – minor updates to drafting plus incorporating comments from Wendy Lowder and Andrew Osborn
4	26.04.21	4	Hill Dickinson – updated diagram and governance Clause 12
5	17.05.21	5	Hill Dickinson – update to Clause 7
6	19.05.21	6	Hill Dickinson – update to incorporate provider collaboration wording and minor amendments from Design Team meeting 19.05.21
7	10.06.21	7	BNHFT mark up
8	18.06.21	8	Hill Dickinson – following BHNFT mark up
9	16.07.21	9	Hill Dickinson – insertion of footnote at 10.4; refs to Health and Care Plan and removal of Priority Programmes, and remit of ICDG included in line with TORs.
10	08.07.22	10	Hill Dickinson – revisions to reflect H&C Act and ICB and post 1 July governance approach
11	20.10.22	11	Minor updates prior to consideration at Barnsley Place Partnership Board
12	7.12.22	12	Clean version prepared with watermark removed etc
12.1	19.1.23	12.1	Minor corrections to names of sub committees to ensure consistency with their ToR

BARNSLEY PLACE AGREEMENT

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Overarching Note – Barnsley Place Agreement

This Agreement provides an overarching framework for the continued development of a place-based partnership for Barnsley. The arrangements set out are intended to build on the existing integrated governance structures between the health and care partners in Barnsley, including the Partnership Board and the Place Partnership Delivery Group, and further strengthen relationships between the Partners for the benefit of the Barnsley population.

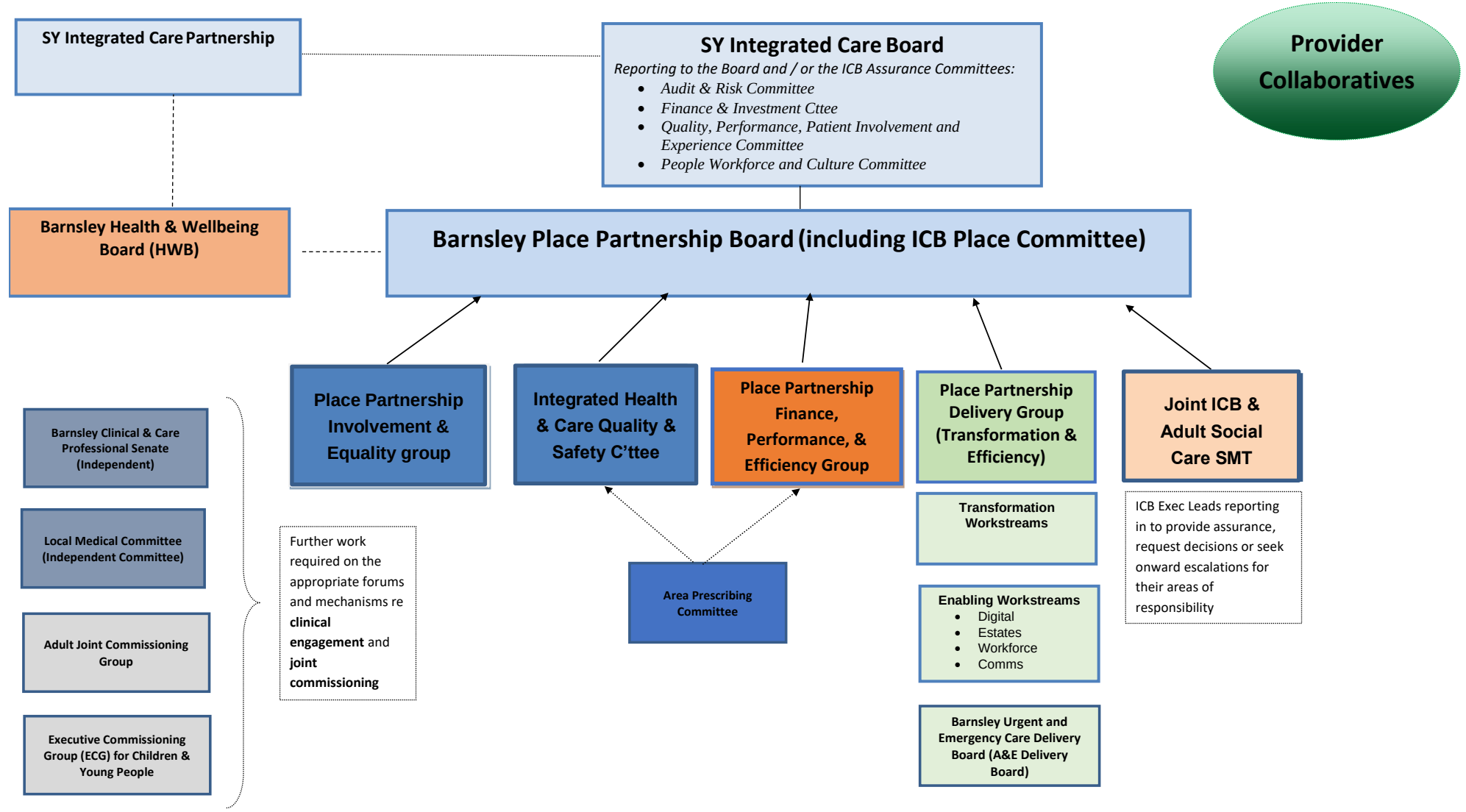
Figure 1 below includes a diagram illustrating the governance arrangements for Barnsley Place Partnership ("Place Partnership") as at the Commencement Date.

This Agreement is designed to work alongside existing NHS Standard Contracts (commonly the Services Contract) and arrangements for the delivery of non-NHS care, support and community services via the Council to the extent such services are within the scope of the Agreement. The Agreement is only intended to be legally binding for specific elements, which are identified, such as confidentiality and intellectual property.

The Partners intend to work together under the governance framework set out in this Agreement to embed and further develop the Place Partnership approach to ultimately include requirements in relation to population health outcomes, risk/gain share, financial and contract management and regulatory requirements, as may be agreed between the Partners. The Partners acknowledge that 2022/23 will be a transitional year during which they will work together through this Agreement to implement a development plan to create a thriving Place Partnership for Barnsley which enables provider collaboration where this aligns with the Place Partnership vision and objectives, and the Barnsley Health and Care Plan.

The Partners will review progress made against the Place Development Plan and the terms of this Agreement on a half yearly basis and/or at such intervals as the Partners may agree thereafter. The Partners may agree to either vary the Agreement to reflect developments or enter into a new agreement.

FIGURE 1 – BARNSLEY PLACE PARTNERSHIP



BARNSLEY PLACE AGREEMENT

DATE: **2022**

This Place Agreement (the **Agreement**) is made between:

1. **NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD** of 722 Prince of Wales Road, Sheffield, S9 4EU ("**ICB**");

2. **BARNSLEY METROPOLITAN BOROUGH COUNCIL** of 1 Westgate, Western Street, Barnsley, S70 2DR ("**Council**");

3. **BARNSLEY HOSPITAL NHS FOUNDATION TRUST** of Gawber Road, Barnsley, S75 2EP ("**BHNFT**");

4. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Ouchthorpe Lane, Wakefield, WF1 3SP ("**SWYPFT**");

5. **BARNSLEY HEALTHCARE FEDERATION COMMUNITY INTEREST COMPANY** (Registered Company No: 09651047) of Oaks Park Primary Care Centre, Thornton Road, Barnsley, S70 3NE ("**BHF**");

6. **BARNSLEY HOSPICE** (Registered Charity No: 700586) of Church Street, Barnsley, S75 2RL ("**BH**"); and

7. **BARNSLEY COMMUNITY AND VOLUNTARY SERVICES** of Pontefract Road, Barnsley, S71 5PN ("**CVS**");

together referred to in this Agreement as the "**Partners**".

The ICB and the Council (in its role as commissioner of social care and public health services) are together referred to in this Agreement as the "**Commissioners**".

BHNFT, SWYPFT, BHF, BH, CVS and the Council (in its role as provider of social care services, whether directly or through contracting arrangements with third party providers) are together referred to in this Agreement as the "**Providers**".

BACKGROUND

(A) The Partners have been working collaboratively across Barnsley to integrate services and provide care closer to home for local people for some time. This Agreement sets out the vision, objectives and shared principles of the Partners in supporting the further development of place-based health and care provision for the people of Barnsley using a population health management approach, building on the progress achieved by the Partners to date.

(B) Pursuant to the Health and Care Act 2022, on the Commencement Date the ICB was

established as a statutory body and NHS Barnsley Clinical Commissioning Group was dissolved and its functions transferred to the ICB. In line with the principle of subsidiarity, the ICB has delegated certain of its functions to be exercised on its behalf by the Place Partnership through the governance arrangements set out in this Agreement.

(C) The Partners will focus on delivery of the Barnsley Health and Care Plan to work towards specific outcomes over the term. Changes or additions to the Health and Care Plan may be identified by the Partners during the term of this Agreement as required to further the collaborative work of the Partners for the benefit of the population of Barnsley. The Place Partnership governance framework will enable the Providers to collaborate in order to identify opportunities for service improvement or redesign in relation to the Health and Care Plan where such opportunities align with the Barnsley Place Partnership vision and objectives.

(D) In light of the Health and Care Act 2022, the Partners recognise that from the Commencement Date they will need to undertake a programme of work through the governance arrangements set out in this Agreement to further develop their place arrangements to become a thriving Place Partnership ready to manage Barnsley resources together for the benefit of the Barnsley population. This programme of work will be set out in a Place Partnership Development Plan to be developed and agreed by the Partners within 3 months of the Commencement Date.

(E) The Partners acknowledge that the delivery and development of the Place Partnership will rely on the Partners working collaboratively rather than separately to plan financially sustainable methods of delivering integrated, population-focused services in furtherance of the Health and Care Plan and the Place Partnership Development Plan.

(F) The Partners acknowledge that the Council has a dual role within the Barnsley health and care system as both a commissioner of social care and public health services but also as a provider of social care services either through direct delivery or through contracts with third party providers. In its role as commissioner of social care services the Council shall work in conjunction with the ICB and in its role as a provider of social care services the Council shall work in conjunction with the Providers. The Council recognises the need to and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified and managed.

(G) This Agreement sets out the key terms that the Partners have agreed, including:

a) the key principles that the Partners will comply with in working together through the Place Partnership;

b) the key objectives for the development and delivery of the Health and Care Plan; and

c) the governance structures underpinning the Place Partnership.

(H) This Agreement is intended to work alongside:

a) the Services Contracts; and

b) the Section 75 Agreement between the ICB and the Council.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

1.2.3 a reference to a "Provider" or a "Commissioner" or any Partner includes its personal representatives, successors or permitted assigns;

1.2.4 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted; and

1.2.5 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 The Partners have agreed to work together on behalf of the people of Barnsley to further develop the Place Partnership through which to identify and respond to the health and care needs of the Barnsley population, and deliver integrated health, support and community care to develop and ultimately deliver improved health and care outcomes for the people of Barnsley.

2.2 Notwithstanding the good faith consideration that each Partner has afforded the terms set out in this Agreement, the Partners agree that, save as provided in Clause 2.3 below, this Agreement shall not be legally binding. The Partners each enter into this Agreement intending to honour all of their respective obligations.

2.3 This Clause 2.3, Clauses 10 (*Transparency*), 17 (*Liability*), 19 (*Confidentiality and FOIA*), 20 (*Intellectual Property*), 21.4 (*Counterparts*) and 21.5 (*Governing Law and Jurisdiction*) shall come into force from the date of this Agreement and shall give rise to legally binding commitments between the Partners.

2.4 Each of the Providers has one or more individual Services Contracts (or where appropriate combined Services Contracts) with the ICB or the Council. This Agreement is not intended to conflict with or take precedence over the terms of the Services Contracts or the Section 75 Agreement unless expressly agreed by the Partners.

3. APPROVALS

Each Partner acknowledges and confirms that as at the date of this Agreement it has obtained all necessary authorisations to enter into this Agreement and that its own organisational leadership body has approved the terms of this Agreement.

4. DURATION AND REVIEW

4.1 This Agreement shall take effect on the Commencement Date (1 July 2022) and will continue in full force and effect until its expiry on 31 March 2024 (the "**Initial Term**"), unless and until terminated in accordance with the terms of this Agreement.

4.2 Prior to the expiry of the Initial Term, this Agreement will expire automatically without notice unless, no later than six (6) months before the end of the Initial Term, the Partners agree in writing that the term of the Agreement will be extended for a further term to be agreed between the Partners (the "**Extended Term**").

4.3 The Partners will review progress made against the Place Partnership Development Plan (once agreed) and the terms of this Agreement on a half yearly basis and/or at such intervals as may be agreed between the Partners and the Partners may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 18 (*Variations*).

SECTION A: VISION, OBJECTIVES AND PRINCIPLES

5. THE VISION

5.1 The Partners have agreed to work towards a common vision for the Place Partnership as follows:

> *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*

6. THE OBJECTIVES

6.1 The Partners have agreed to work together and to perform their duties under this Agreement in order to achieve the following Objectives:

6.1.1 Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each Partner delivering their part without duplication;

6.1.2 Individuals, families and communities are empowered to take control wherever possible of their own health and wellbeing;

6.1.3 Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance;

6.1.4 Embed integrated care that delivers the best value for the Barnsley pound;

6.1.5 Develop population health management approaches to improve health and wellbeing and reduce health inequalities;

6.1.6 Work towards becoming a thriving Place Partnership in accordance with the Place Partnership Development Plan for 2022/23 and beyond; and

6.1.7 Play a pivotal role in delivering our shared vision for Barnsley: a place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.

6.2 The Partners acknowledge that they will have to make decisions together in order for the Place Partnership arrangements to work effectively. The Partners agree that they will work together and make decisions on a Best for Barnsley basis in order to achieve the Objectives, save for the Reserved Matters listed at Clause 9.

7. THE PRINCIPLES

7.1 These Principles underpin the delivery of the Partners' obligations under this Agreement and set out key factors for a successful relationship between the Partners for the delivery of the Place Partnership.

7.2 The Partners agree that the successful delivery of the Place Partnership operating model will depend on their ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the planning, provision and use of community assets and services across the Partners.

7.3 The Partners will work together in good faith and, unless the provisions in this Agreement state otherwise, the Partners will:

7.3.1 Aim for better health and wellbeing for the whole population, better quality care for all patients and sustainable services for the taxpayer alongside the reduction of health inequalities (the “quadruple aim”);

7.3.2 Play our part in social and economic development and environmental sustainability of Barnsley and the wider South Yorkshire region;

7.3.3 Commit to making decisions at the right level and with the relevant partners at the Place Partnership level to deliver the Place Partnership vision and the Shared Purpose and benefit the population of Barnsley and the wider South Yorkshire region. Decisions should not adversely affect the outcomes or equity for populations within Barnsley or the ICS;

7.3.4 Ensure that the children’s, young people and families’ agenda is a key element of the Place Partnership’s work;

7.3.5 Support each other and work collaboratively to take decisions at the most local level as close as possible to the communities that we affect whether that be system, place or neighbourhood (subsidiarity);

7.3.6 Develop collaborative system leadership encompassing health, social care and wider system partners to deliver the Place Partnership vision and the Shared Purpose, and a culture and values to support transformation. All members are respected and valued. They understand their own contribution and support the contributions of other members to the Place Partnership vision and the Shared Purpose;

7.3.7 Strengthen clinical and professional leadership including general practitioners as expert generalists with the patient;

7.3.8 Enable the leadership role of citizens, communities and voluntary sector;

7.3.9 Strengthen the links between neighbourhoods, Place and the ICS and demonstrate inclusivity and shared ownership;

7.3.10 Make time and other resources available to develop the Place Partnership and deepen working relationships between the Partners at all levels;

7.3.11 Be transparent with each other and the people of Barnsley and the wider South Yorkshire area around decisions and appointments;

7.3.12 Use the best available data to inform priorities and decision-making;

7.3.13 Look for simplicity and effectiveness in any Place Partnership structures and governance and follow the rule of form following function;

7.3.14 Act with honesty and integrity and trust that each other will do the same. This includes each Partner being open about the interests of their organisation and any disagreement they have with a proposal or analysis. The Partners will assume that each acts with good intentions;

7.3.15 Work to understand the perspective and impacts of their decisions on other parts of the health and social care system;

7.3.16 Adopt an asset based approach that is citizen-led, relationship orientated, asset based, place-based and inclusion focussed;

7.3.17 Provide a proactive and person-centred approach that empowers patients and addresses people's needs;

7.3.18 Improve quality and efficiency of services through sharing records, data and information including integrated information management and technology;

7.3.19 Support the delivery of more enhanced and specialised services in the community where appropriate;

7.3.20 Neighbourhood focus for delivery of services whilst ensuring services are wrapped around patients and aligned to GP practices;

7.3.21 Focus on self-care to promote independence and reduce pressures on the health and care system;

7.3.22 Focus on prevention including the wider determinants of health and understanding the perspective and impacts of our decision on other parts of the health and social care system;

7.3.23 Maximise the agreed outcomes within the resources available to deliver best possible value for the Barnsley pound;

7.3.24 Promote and strive to adhere to the Nolan Principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership);

7.3.25 Being accountable to each other for the performance of respective roles and responsibilities for the Place Partnership and the ICS, in particular where there is an interface with other Partners;

7.3.26 Communicating openly about major concerns, issues or opportunities relating to this Agreement and adopt transparency as a core value, including through open book reporting and accounting, subject always to appropriate treatment of Commercially Sensitive Information if applicable;

7.3.27 Having conversations about supporting the wider health and care system, not just furthering our own organisation's interests;

7.3.28 Undertaking more aligned decision-making across the Partners and trying to commission and deliver services in an integrated way wherever reasonably possible;

7.3.29 Using insights from data to inform decision making;

7.3.30 Engaging positively with other partners in other geographies in pursuit of the aim described at 7.3.1 and effective planning and delivery;

7.3.31 Ensuring that problems are resolved where possible rather than being moved around the system; and

7.3.32 Acting promptly. Recognising the importance of integrated working and the Place Partnership and responding to requests for support from other Partners,

and these are the "**Principles**".

8. PROBLEM RESOLUTION AND ESCALATION

8.1 The Partners agree to adopt a systematic approach to problem resolution which recognises the Objectives and the Principles set out in Clauses 6 and 7 above and which:

8.1.1 seeks solutions without apportioning blame;

8.1.2 is based on mutually beneficial outcomes;

8.1.3 treats each Partner as an equal party in the dispute resolution process; and

8.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

8.2 If a problem, issue, concern or complaint comes to the attention of a Partner in relation to the Objectives, Principles or any matter in this Agreement and is appropriate for resolution between the Partners such Partner shall notify the other Partners and the

Partners each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion within 20 Operational Days of such matter being notified.

8.3 Any Dispute arising between the Partners which is not resolved under Clause 8.2 above will be resolved in accordance with Schedule 3 (*Dispute Resolution Procedure*).

8.4 If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this Agreement) the receiving Partner will liaise with the Place Partnership Board as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE SYSTEM

9. RESERVED MATTERS

9.1 The Partners agree and acknowledge that nothing in this Agreement shall operate as to require them to make any decision or act in anyway which shall place any Partner in breach of:

9.1.1 Law;

9.1.2 any Services Contract or the Section 75 Agreement;

9.1.3 any specific Department of Health and Social Care or NHS England policies;

9.1.4 if applicable its constitution; any terms of its NHS provider licence; its registration with the CQC; the terms of reference of the Partnership Board; or any legislative requirements including the NHS Act 2006 (as amended); and

9.1.5 any term of a non-NHS party's legal constitution or other legally binding agreement or governance document of which specific written notice has been given to the Partners prior to the date of the Agreement,

and the Partnership Board will not make a final recommendation which requires any Partner to act as such.

10. TRANSPARENCY

10.1 Subject to Clause 10.4, the Partners will provide to each other all information that is reasonably required in order to deliver the Health and Care Plan and implement the Place Partnership Development Plan in line with the Objectives.

10.2 The Partners have responsibilities to comply with Law (including where applicable Competition Law). The Partners will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, the Partnership Board and the Place Partnership

Delivery Group will each ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

10.2.1 it is essential;

10.2.2 it is not exchanged more widely than necessary;

10.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

10.2.4 it may not be used other than to achieve the Objectives in accordance with the Principles.

10.3 The Commissioners will make sure that the Place Partnership Delivery Group establishes appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the Objectives and for no other purpose whatsoever so that the Partners do not breach Competition Law.

10.4 It is accepted by the Partners that the involvement of the Providers in the governance arrangements for the Place Partnership is likely to give rise to situations where information will be generated and made available to the Providers which could potentially give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the ICB and/or the Council (where acting as a commissioner) in relation to any competitive procurements that the information it has acquired as a result of its participation in the Place Partnership, other than as a result of a breach of this Agreement, does not preclude the ICB and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations. A Provider shall not be obliged to provide any information which in its reasonable opinion would provide any other Partner with an unfair advantage in any competition or would distort competition.

10.5 Notwithstanding Clause 10.4 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law which may include excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

SECTION C: GOVERNANCE ARRANGEMENTS

11. GOVERNANCE

11.1 The governance structure for the Place Partnership is set out in the diagram in Schedule 2 and includes the following:

11.1.1 the Partnership Board; and

11.1.2 the System Groups.

Partnership Board

11.2 The Partnership Board in practice carries out two roles:

11.2.1 firstly, the Partnership Board has responsibility for aligning decisions on strategic policy matters made by Partners that are relevant to the Place Partnership. Where applicable, the Partnership Board may also make recommendations on matters that it has been asked to consider on behalf of a constituent Partner in the Place Partnership. Where the Partnership Board has been asked to consider matters on behalf of a Partner, the Partner organisation remains responsible for the exercise of its functions and nothing that the Partnership Board does shall restrict or undermine that responsibility. This work is referred to as "**Partnership Business**"; and

11.2.2 secondly, the Partnership Board sits as the ICB Place Committee for Barnsley ("**ICB Place Committee**"), which is a formal committee of the ICB. The ICB Place Committee is established as a committee of the ICB Board, in accordance with the ICB's Constitution. The ICB Place Committee has delegated authority from the ICB Board to make decisions about the use of ICB resources in Barnsley in line with its remit, and otherwise support the ICB as set out in its terms of reference of Schedule 2. The decisions reached by the ICB Place Committee are decisions of the ICB, in line with the ICB's Scheme of Reservation and Delegation. This work is referred to as "**ICB Business**". When sitting as the ICB Place Committee, Partners must comply with ICB policies and procedures.

11.3 As far as possible, the Partners that are statutory bodies will exercise their respective statutory functions within the Partnership Board governance structure to the extent they are within the scope of these arrangements. This will be enabled:

11.3.1 for the ICB, through the Partnership Board sitting as the ICB Place Committee, as outlined above;

11.3.2 for other Partners that are statutory bodies, through those organisations granting delegated authority for decision making to specific individuals (for example a

Partnership Board member) or to specific committees or other structures established by Partner organisations meeting as part of, or in parallel with, the Partnership Board; and

11.3.3 for Partners that are not statutory bodies, it is expected that as far as possible the individuals attending meetings of the Partnership Board will be formally authorised to take the decisions under consideration on behalf of their organisation.

11.4 The terms of reference at Part 2 of Schedule 2 apply to Partnership Business as at the Commencement Date. The terms of reference at Part 3 of Schedule 2 apply to the ICB Place Committee (ICB Business) as at the Commencement Date and can be found in the governance handbook issued by the ICB and available on the ICB website. The terms of reference for all governance groups may be updated by agreement of the Partners during the term or as otherwise stated in their terms.

11.5 Whether decisions are Partnership Business or ICB Business or a combination of the two, the aim will be to ensure that decisions reflect applicable national and local strategies and are taken in accordance with the Vision, Objectives and Principles for the Place Partnership.

11.6 The Partnership Board will report to Partner organisations and is the group responsible for:

11.6.1 overseeing the Place Partnership arrangements under the Agreement;

11.6.2 reporting to the Health and Wellbeing Boards on progress against the Objectives; and

11.6.3 liaising where appropriate with national stakeholders (including NHS England),

to communicate the views of the Place Partnership on matters relating to integrated care in Barnsley.

11.7 The Partnership Board will act in accordance with its terms of reference set out in Schedule 2 as applicable.

11.8 A key principle agreed by the Partners is that the chair of the Partnership Board when undertaking Partnership Business will rotate between the Partner organisations.

11.9 Where agreed by the ICB and the Council the Partnership Board may meet in common with the joint commissioning governance arrangements between the ICB and the Council.

System Groups

11.10 The System Groups are established by the Partnership Board and are responsible for developing a system-wide approach in their respective areas of focus. The System Groups established as at the Commencement Date are set out in the diagram at Schedule 2 and include:

11.10.1 the Place Partnership Involvement & Equality Group;

11.10.2 the Integrated Health & Care Quality & Safety Committee;

11.10.3 the Place Partnership Finance, Performance & Efficiency Group; and

11.10.4 the Place Partnership Delivery Group.

11.11 The System Groups will provide advice and assurance to the Partnership Board in their areas of focus and play a key role in driving improvement across the Place Partnership. The System Groups report to the Partnership Board and their terms of reference will be agreed by the Partners following the Commencement Date. The System Groups shall not be a committee of any Partner or any combination of Partners and each System Group shall operate as a collaborative forum.

11.12 The Partners will communicate with each other clearly, directly and in a timely manner to ensure that the Partners (and their representatives) present at the Partnership Board and any System Groups are able to represent their nominating organisations to enable effective and timely recommendations to be made in relation to the Health and Care Plan and the Place Partnership Development Plan.

11.13 Each Partner must ensure that its appointed members of the Partnership Board and System Groups (or their appointed deputies/alternatives) attend all of the meetings of the relevant group and participate fully and exercise their rights on a Best for Barnsley basis and in accordance with Clause 5 (Objectives) and Clause 7 (Principles).

11.14 The Partners agree that the governance arrangements set out in this Clause 11 will be further refined over the Initial Term.

12. CONFLICTS OF INTEREST

12.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality the Partners agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner.

12.2 The Partners will:

12.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the operation of the Partnership Board or the PPDG immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of this Agreement;

12.2.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and

12.2.3 use best endeavours to ensure that their representatives on the Partnership Board and the PPDG also comply with the requirements of this Clause 12 when acting in connection with this Agreement.

SECTION D: FINANCIAL PLANNING

13. PAYMENTS

13.1 The Providers who provide services will continue to be paid in accordance with the mechanism set out in their respective Services Contracts.

13.2 The Partners have not agreed as at the Commencement Date to share risk or reward.

13.3 The Partners will work together during the Initial Term through the Finance, Performance and Efficiency Group to consider and bring forward a proposal to develop system financial principles including potential risk/reward sharing mechanisms.

SECTION E: FUTURE DEVELOPMENT OF THE PLACE PARTNERSHIP

14. PLACE PARTNERSHIP DEVELOPMENT PLAN

14.1 The Partners have agreed to work together to develop the Place Partnership Development Plan to enable maximum delegation to a weight-bearing Barnsley Place Partnership able to receive and make decisions about Barnsley's resource allocation. Once agreed, the Partners will keep the Place Partnership Development Plan under review through the governance structures set out in this Agreement and may agree to amend the Place Partnership Development Plan as required during the Initial Term, in line with policy direction and legislative developments.

SECTION F: GENERAL PROVISIONS

15. EXCLUSION AND TERMINATION

15.1 A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus) in the event of:

15.1.1 the termination of their Services Contract; or

15.1.2 an event of Insolvency affecting them.

15.2 A Partner may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Partners' representatives.

15.3 A Partner may be excluded from this Agreement on written notice from all of the remaining Partners in the event of a material or a persistent breach of the terms of this Agreement by the relevant Partner which has not been rectified within 30 days of notification issued by the remaining Partners (acting in consensus) or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Partner.

15.4 The Partnership Board may resolve to terminate this Agreement in whole where:

15.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

15.4.2 where the Partners agree for this Agreement to be replaced by a formal legally binding agreement between them.

15.5 Where a Partner is excluded from this Agreement, or withdraws from it, the excluded or withdrawing (as relevant) Partner shall procure that all data and other material belonging to any other Partner shall be delivered back to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

15.6 For the avoidance of doubt, individuals sitting as members of the Partnership Board may be removed and/ or may be prevented from participating in meetings in accordance with the terms of reference set out in Schedule 2.

16. INTRODUCING NEW PARTNERS

Additional parties may become parties to this Agreement on such terms as the Partners shall jointly agree in writing, acting at all times on a Best for Barnsley basis. Any new Partner will be required to agree in writing to the terms of this Agreement before admission.

17. LIABILITY

The Partners' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Services Contracts and not this Agreement.

18. VARIATIONS

Any amendment to this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Partners, provided always that the ICB will be able to amend the terms of reference for the ICB Place Committee and ICB Business set out in Schedule 2 without the need for approval from the other Partners.

19. CONFIDENTIALITY AND FOIA

19.1 Each Partner shall keep confidential all Confidential Information that it receives from the other Partners except to extent such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner to this Agreement.

19.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

19.3 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 19 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

19.4 Nothing in this Clause 19 (*Confidentiality and FOIA*) will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

19.5 The Partners acknowledge that some of them are subject to the requirements of the FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that any Partner which is subject to FOIA is able to comply with their statutory obligations.

20. INTELLECTUAL PROPERTY

20.1 In order to develop and deliver the arrangements under this Agreement in accordance with the Principles each Partner grants each of the other Partners a fully paid up, non-

exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Partner's obligations under this Agreement.

20.2 If any Partner creates any new Intellectual Property through the development and delivery of the arrangements under this Agreement, the Partner which creates the new Intellectual Property will grant to the other Partners a fully paid up, non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations and the development and delivery of the arrangements under this Agreement.

21. GENERAL

21.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

21.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 21.1 above; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

21.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

21.4 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

21.5 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

21.6 A person who is not a Partner to this Agreement shall not have any rights under or in connection with it.

This Agreement has been entered into on the date stated at the beginning of it.

Signed by [insert] .....

for and on behalf of **NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD** [ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY METROPOLITAN BOROUGH COUNCIL** [ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY HOSPITAL NHS FOUNDATION TRUST** [ ]

Signed by [insert] .....

for and on behalf of **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** [ ]

Signed by [insert]

for and on behalf of **BARNSLEY HEALTHCARE** .....

FEDERATION	[ ]
Signed by [insert]	.....
for and on behalf of **BARNSLEY HOSPICE**	[ ]
Signed by [insert]	.....
for and on behalf of **BARNSLEY COMMUNITY AND VOLUNTARY SERVICES**	[ ]

Healthwatch Barnsley *is the independent consumer champion created to gather and represent the views of the public in Barnsley. As it does not exist as a separate legal entity, it is not a party to this Agreement and cannot be bound by the terms of this Agreement, but signs this Agreement below to confirm its support for the Place Partnership, its vision, objectives and principles, and agrees to participate in the Place Partnership governance structure.*

Signed by [insert]	.....
for and on behalf of **HEALTHWATCH BARNSLEY**	[ ]

SCHEDULE 1

Definitions and Interpretation

1. The following words and phrases have the following meanings:

Agreement	this agreement incorporating the Schedules.
Best for Barnsley	best for the achievement of the Objectives and the Outcomes for the Barnsley population on the basis of the Principles.
Commencement Date	1 July 2022.
Commercially Sensitive Information	Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss.
Competition Law	the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector in accordance with the Health and Care Act 2022.
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions.
Confidential Information	the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including

	Commercially Sensitive Information and Competition Sensitive Information.
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in Schedule 3 for the resolution of disputes which are not capable of resolution under Clause 0 (*Problem Resolution and Escalation*).
Extended Term	has the meaning set out in Clause 4.2.
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act.
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Services Contracts), as appropriate.
Health and Care Plan	the Barnsley Health and Care Plan, available at [insert link].
ICS	Integrated Care System.
Initial Term	the period from and including the Commencement Date until 31 March 2024.
Insolvency	(as may be applicable to each Partner) a Partner taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business.
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent

	rights or forms of protection which subsist or will subsist now or in the future in any part of the world.
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code.
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time.
Objectives	the objectives for the Place Partnership set out in Clause 6.1.
Operational Days	a day other than a Saturday, Sunday or bank holiday in England.
Partnership Board	the Barnsley Place Partnership Board, the terms of reference for which are set out in Schedule 2 (Governance).
Place Partnership Development Plan	the Place Partnership Development Plan to be agreed between the Partners following the Commencement Date.
Place Partnership Delivery Group or PPDG	the Place Partnership Delivery Group, the terms of reference for which will be agreed by the Partners following the Commencement Date
Population	the population of Barnsley covered by each of the Commissioners.
Principles	the principles for the Place Partnership set out in Clause 7.
Reserved Matter	has the meaning set out in Clause **Error! Reference source not found.**.
Section 75 Agreement	the agreement entered into by the Commissioners under section 75 of the National Health Service Act 2006 to commission the services listed in the schedules to that agreement.
Service Users	people within the Barnsley population served by the Commissioners and who are in receipt of the Services.
Services	the services provided, or to be provided, by each Provider to Service Users pursuant to its respective Services Contract.

Services Contract	a contract entered into by one of the ICB or the Council and a Provider for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires.
Shared Purpose	the shared purpose of the South Yorkshire ICS to deliver the quadruple aim (better health, care, value and reduced inequalities) in order to improve population health outcomes and reduce health inequalities for the population of South Yorkshire.
System Groups	the system groups reporting into the Partnership Board, as referred to in Clause 11.10.

SCHEDULE 2

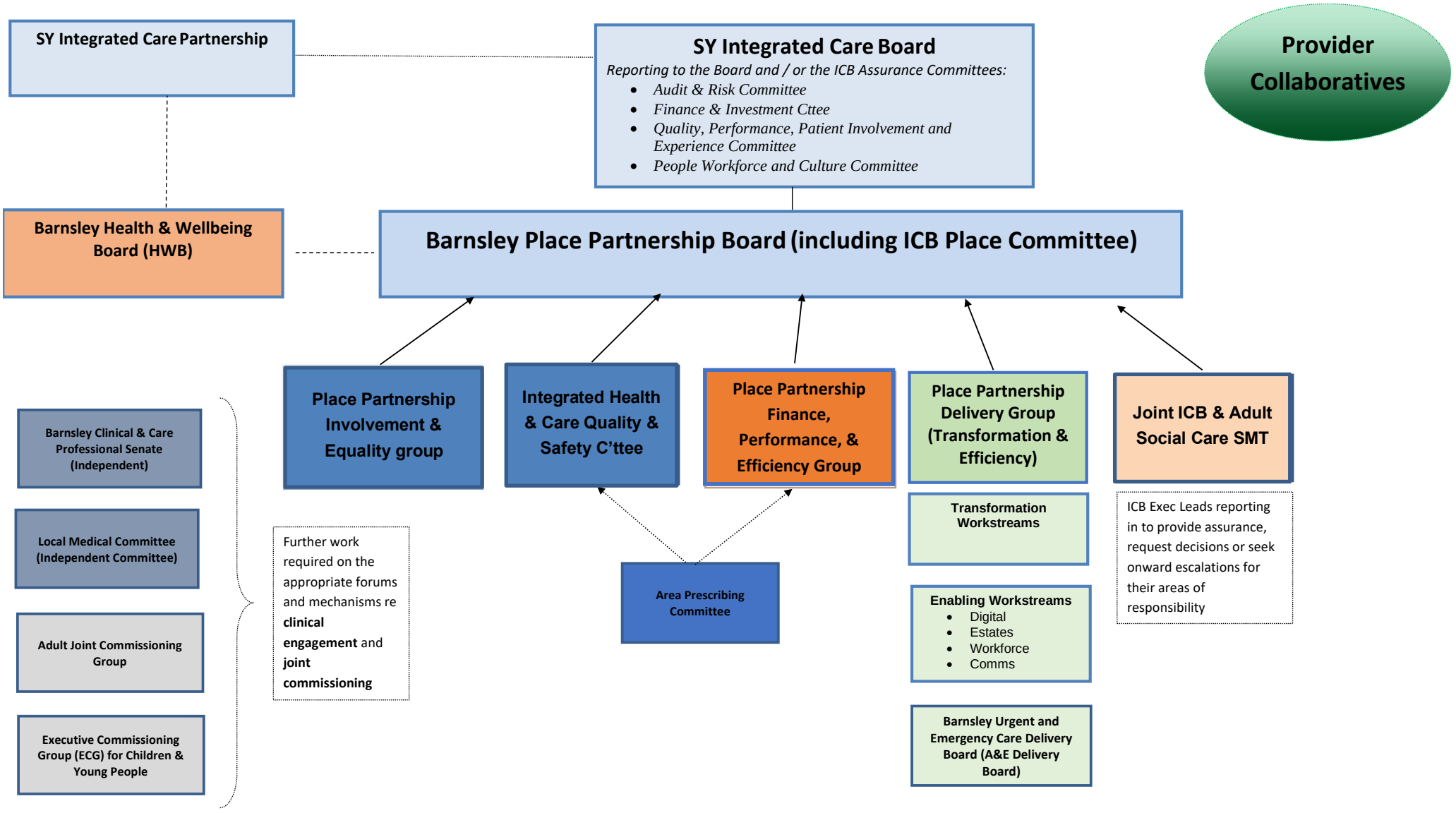
Governance

This Schedule 2 sets out the governance arrangements for the Place Partnership under this Agreement as at the Commencement Date.

The diagram below summarises the governance structure which the Partners have agreed to establish and operate from the Commencement Date, to provide oversight of the development and implementation of the Place Partnership approach and the arrangements under this Agreement.

This Schedule also contains the terms of reference for the Partnership Board. The terms of reference for other governance groups will be finalised and agreed by the Partners following the Commencement Date.

Overview of the Barnsley Place Partnership governance model



Barnsley Partnership Board - Terms of Reference

The Terms of Reference of the Barnsley Place Partnership Board received formal approval at its meeting on 24 November 2022 and are embedded below:

FINAL Barnsley Partnership Board TOI

SCHEDULE 3

Dispute Resolution Procedure

1. Avoiding and Solving Disputes

1.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 0 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Partners believe that by focusing on their agreed Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the Place Partnership arrangements set out in this Agreement.

1.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the Place Partnership (each a '**Dispute**') when it arises.

1.4 In the first instance the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Partners, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for Barnsley basis in accordance with this Agreement so as to seek to reach a unanimous decision.

1.5 The Partners agree that the senior officers may, on a Best for Barnsley basis, determine whatever action it believes is necessary including the following:

1.5.1 If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and

1.5.2 The independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure;

(iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed or such longer period as may be agreed between the Partners in Dispute; and

(v) have its costs and disbursements met by the Partners in Dispute equally.

1.5.3 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 3 and only after such further consideration again fails to resolve the Dispute, the Partners may agree to:

(i) terminate this Agreement in accordance with Clause 15.1.1; or

(ii) agree that the Dispute need not be resolved.

BARNSLEY PLACE PARTNERSHIP PARTNERSHIP BOARD AND ICB PLACE COMMITTEE Terms of Reference	
Version	**3**
Implementation Date	**24th November 2022**
Review Date	**[1 April 2023]**
Approved By	**Barnsley Place Partnership Board and ICB Place Committee**
Approval Date	**24th November 2022**

VERSIONS			
Date	**Version**	**Comments**	**Author**
17 June 2022	**1**	Initial draft for feedback	**Hill Dickinson**
24 June 2022	**2.3**	Incorporating ICB comments regarding ICB committee (RM)	**Hill Dickinson**
8 July 2022	**2.4**	Incorporating	**Hill Dickinson**
20 October 2022	**2.5**	Amendments prior to resubmission to Place Partnership Board on 28 October 2022	**Richard Walker / Jeremy Budd**
3 November 2022	**2.6**	At request of WL and RN the ICB Head of Comms & Engagement has been added in as an attendee of the Place Committee & Place Partnership.	**Richard Walker**
15 November 2022	**2.7**	Updated to finalise place partnership board membership and participants and also quoracy – following advice from Hill Dickinson	**Jeremy Budd**
7 December 2022	**3**	Final 'clean' version with draft watermark removed	**Richard Walker**

1. Structure of these Terms of Reference

These terms of reference are divided into three sections:

Part 1: Background;
Part 2: Terms of reference for the Barnsley Partnership Board when carrying out Partnership Business (defined below); and
Part 3: Terms of reference for the Barnsley Partnership Board when carrying out ICB Business (defined below) as a committee of NHS South Yorkshire Integrated Care Board.

PART 1: BACKGROUND

1. The organisations referred to in these terms of reference are Partners in the Barnsley Place Partnership ("**Place Partnership**"). Representatives of the Partners have come together as the Barnsley Partnership Board ("**Partnership Board**") to enable the delivery of integrated population health and care services in Barnsley, as set out in more detail below. The Partners have entered into a Place Agreement setting out their commitment to delivery of the Barnsley vision, objectives, and principles (as documented in the Place Agreement).

2. The Partnership Board in practice carries out two roles:

- Firstly, the Partnership Board is responsible for aligning decisions on strategic policy matters made by Place Partners that are relevant to the achievement of the Barnsley Place Plan, in accordance with its terms of reference in Part 2. Where applicable, the Partnership Board may also make recommendations on matters that it has been asked to consider on behalf of a constituent Partner in the Place Partnership. Where the Partnership Board has been asked to consider matters on behalf of a Partner, the Partner organisation remains responsible for the exercise of its functions and nothing that the Partnership Board does shall restrict or undermine that responsibility. This work is referred to as "**Partnership Business**".

- Secondly, the Partnership Board sits as the Barnsley ICB Committee ("**ICB Place Committee**"), which is a committee of the NHS South Yorkshire Integrated Care Board ("**ICB**"). The ICB Place Committee is established as a committee of the ICB Board, in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation & Delegation. When the Partnership Board sits as the ICB Place Committee it has delegated authority from the ICB Board to make decisions about the use of ICB resources in Barnsley in line with its remit, and otherwise support the ICB as set out in its terms of reference in Part 3 with the membership as set out in paragraph 7 below. The decisions reached by the ICB Place Committee are decisions of the ICB, in line with the ICB's Scheme of Reservation & Delegation **"ICB Business"**. When sitting as the ICB Place Committee, members must comply with ICB policies and procedures.

3. As far as possible, the Partners that are statutory bodies will exercise their respective statutory functions within the Partnership Board governance structure. This will be enabled:

- For the ICB, through the Partnership Board sitting as the ICB Place Committee, as outlined above

- For other Partners that are statutory bodies, through those organisations granting delegated authority for decision making to specific individuals (for example a Partnership Board member) or to specific committees or other structures established by Partner organisations meeting as part of, or in parallel with, the Partnership Board.

4. For Partners that are not statutory bodies, it is expected that as far as possible the individuals attending meetings of the Partnership Board will be authorised to take the decisions under consideration on behalf of their organisation.

5. It is expected that in many cases, ICB Business, or any other reserved statutory decisions taken by individuals on behalf of their statutory organisations, will be able to be conducted at meetings of the Partnership Board, as a result of either individual Partner representatives exercising delegated authority or through the ICB Place Committee making the decision as a committee. Other representatives of Partner organisations will be attendees at the Partnership Board at such times subject to the management of any conflicts of interest.

6. Whether decisions are taken under Part 2 and Part 3, or only Part 2 or Part 3 of these terms of reference, the aim will be to ensure that decisions reflect applicable national and local priority objectives and strategies and are taken in accordance with the collaborative principles for the Place Partnership.

7. Membership and attendance at the Partnership Board differs according to whether or not the Partnership Board is undertaking Partnership Business or ICB Business in accordance with the relevant terms of reference. The table below sets out the status of individual representatives in each case for ease of reference:

Nominated Representative (Role/Title)	Organisation	Status for Partnership Business	Status for ICB Business
Chair	South West Yorkshire Partnership NHS Foundation Trust	Chair (to be rotated every 12 months)	Participant
Chief Executive	Barnsley Hospital NHS Foundation Trust	Member	Participant
Chair	Barnsley Hospital NHS Foundation Trust	Member	Participant
Leader	Barnsley Metropolitan Borough Council	Member	Participant
Chief Executive	Barnsley Metropolitan Borough Council	Member	Participant
Director of Public Health	Barnsley Metropolitan Borough Council	Member	Participant
Chief Executive	Barnsley Healthcare Federation	Member	Participant
Chair	Barnsley Healthcare Federation	Member	Participant
Chief Executive	South West Yorkshire Partnership NHS Foundation Trust	Member	Participant
Chief Executive	Barnsley Hospice Chief Executive	Member	Participant
Chair or Chief Executive	Barnsley CVS	Member	Participant
Chair or Chief Executive	Barnsley Primary Care Network	Member	Participant
Executive Place Director	NHS South Yorkshire Integrated Care Board	Member	Chair
Chief Nurse, Barnsley Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Medical Director, Barnsley Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Chief Finance Officer, Barnsley Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board	Member	Member
Head of Comms & Engagement, Barnsley Place	NHS South Yorkshire Integrated Care Board	Participant	Participant
Chair	Healthwatch	Participant	Participant

BARNSLEY PARTNERSHIP BOARD

PART 2: PARTNERSHIP BOARD – TERMS OF REFERENCE FOR PARTNERSHIP BUSINESS

1	**Name of committee**	The Barnsley Partnership Board (the "**Partnership Board**").
2	**General**	In these terms of reference the following capitalised terms are given the meaning set out in the NHS South Yorkshire Integrated Care Board ("**ICB**") Constitution as updated from time to time, unless the context otherwise requires: Constitution ICB Standing Order or Standing Orders
		Other capitalised terms have the meaning set out below: "Barnsley Plan" means the Barnsley Health and Care Plan as agreed by the Partnership, aligned to NHS South Yorkshire "Chair" means the chair of the Partnership Board "Executive Place Director" means that individual appointed by the ICB to oversee and help develop the Place Partnership "ICB Business" has the meaning set out in Part 1 "ICB Place Committee" means the committee of the ICB for the Barnsley Place "ICB Policies" means any policy, process or procedure formally adopted by the ICB "Member" refers to a member of the Partnership Board as listed in paragraph 0 "Participant" refers to a participant of the Partnership Board as listed in paragraph 7 "Partner" refers to a partner organisation in the Place Partnership which is also a party to the Place Agreement "Partnership Board" means the Partnership Board as described in the Place Agreement that also sits as the ICB Place Committee as described in the ICB Constitution "Partnership Business" has the meaning set out in Part 1 "Place Agreement" means the agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Barnsley "Place Partnership" means the partnership of organisations described in the Place Agreement "Terms of Reference for ICB Business" means the terms of reference set out in Part 3 "Working Days" means a weekday that is not a bank holiday in England.

3	**Reports to**	The Partnership Board reports to the boards of the Partners in relation to Partnership Business. This is done through each Partner representative sitting on the Partnership Board reporting back to their respective employing/ host organisation.

4	**Purpose**	The purpose of the Partnership Board is to provide visible leadership, direction and commitment to the vision and objectives for developing integrated care in Barnsley (as set out in the Place Agreement) and ensuring effective governance, communication and delivery of the objectives.
		
		The Partnership Board will work together to achieve the vision and objectives of the Place Partnership through:
		
		• providing strategic and operational oversight
		• developing new models of joined up services in communities that:
		  ○ set out a new relationship with residents in neighbourhoods
		  ○ are person centred, with a focus on supported self-care, prevention and asset based
		  ○ ensure that services developed in neighbourhoods and new primary care networks are complementary in both services and governance.
		  ○ take a 'one public sector – one borough - one team' approach
		• providing shared responses to the South Yorkshire Integrated Care System (SYICS) strategic developments on primary care networks and other associated integration requirements, including the horizontal provider collaboratives
		• producing shared communications
		• developing shared information governance and record keeping
		• developing a shared workforce strategy
		• developing a shared understanding of collective finances with the aim of a shared management of financial risk
		• considering investment decisions across the Place Partnership
		• having regard to the strategy developed by the Barnsley Health and Wellbeing Board
		
		Ultimately this will ensure that the Partners work together to drive efficiencies and better outcomes for the residents of Barnsley, in line with the Barnsley Plan.
		
		Oversee and inform the work of the Place Partnership Development Group providing support and strategic decision making either directly, within their scope of delegated authority, or by making recommendations to sovereign organisation Boards/relevant decision making bodies.
		
		Review and if appropriate, adapt the Barnsley Plan's objectives, milestones and governance in light of internal or external strategic changes.

5	**Remit and responsibilities**	When conducting Partnership Business, the Partnership Board has responsibility for: • Providing mutual assurance to the constituent Partners through regular reports to their boards • Reflecting the underlying principles as set out within the Place Agreement • Reviewing progress and guiding the Barnsley Health & Care Plan and Place Partnership Delivery Plan towards the overall agreed objectives and benefits • Ensuring all risk is assessed and assure that mitigating actions are in place • Making best use of the Barnsley £ putting Barnsley people first ahead of the needs of individual Partner organisations. In doing so, to collectively manage risk through effective arrangements between partner organisations that meet regulatory requirements and develop a collective voice in managing our position with the SYICS. • Working within the overall scope of the Programme, recognising that changes will be agreed during the course of its development and introduction. • Supporting the Place Partnership Development Group to deliver the

		Programme objectives • Strategic decision making for issues raised by the Place Partnership Development Group within the scope of delegated authority to the Partnership Board members • Helping to develop clinical models and partnership priorities in line with mature partnership arrangements. For the avoidance of doubt, the Partnership Board will not have the final decision on clinical/operational models or the commissioning intentions of the Place Partnership.
6	**Members**	Members contribute to discussion, participate in aligned decision making and are accountable for decisions made. The Members of the Partnership Board when undertaking Partnership Business are: • Partner organisation rotation - Chair of the Partnership Board • Barnsley Hospital NHS Foundation Trust ("**BHNFT**") – Chief Executive • BHNFT – Chair • Barnsley Metropolitan Borough Council ("**BMBC")** – Leader of the Council • BMBC Chief Executive • BMBC Director of Public Health • Barnsley Healthcare Federation ("**BHF**") – Chief Executive • BHF – Chair • South West Yorkshire Partnership NHS Foundation Trust ("**SWYPFT**") – Chair • SWYPFT – Chief Executive • Barnsley Hospice - Chief Executive • Barnsley CVS – Chair or Chief Executive • Barnsley PCN - Chair or Chief Executive • Executive Place Director, Barnsley Place Partnership (ICB) Membership will be reviewed and adjusted as necessary to ensure the Partnership Board meets its responsibilities. The role of Chair of the Partnership Board for Partnership Business will be rotated to another Member of the Partnership Board as agreed by the Members. This will be undertaken on an annual basis at the beginning of every financial year. The same organisation cannot hold the Chair position in both the Partnership Board and the Place Partnership Development Group at the same time.
7	**Participants**	The following individuals will be invited to attend each meeting of the Partnership Board as Participants. Participants attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not participate in decision making. The Participants of the Partnership Board when undertaking Partnership Business are: • Healthwatch – Chair • Place Partnership Development Group executive members • ICB – Chief Nurse, Barnsley Place • ICB - Chief Finance Officer, Barnsley Place • ICB – Medical Director, Barnsley Place • Head of Comms & Engagement, Barnsley Place The Chair may invite such other Participants to attend any meeting of the Partnership Board as the Chair considers appropriate.
8	**Deputies**	With the permission of the Chair, Members of the Partnership Board may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated

		deputies is final.
9	**Chair**	The meetings will be run by the Chair of the Partnership Board for Partnership Business (as noted in paragraph 6 above). In the event of the Chair being unable to attend all or part of the meeting, another Member of the Partnership Board shall chair the meeting.
10	**Quoracy**	No business shall be transacted unless at least 50% of the Partnership Board membership (which equates to 7 individuals) are present. This will include at minimum one member from each of the ICB and BMBC and at minimum 5 members drawn from the other Partner organisations. For the sake of clarity: a) No person can act in more than one capacity when determining the quorum. b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum. Members of the Partnership Board may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year
11	**Conduct of meetings**	The Partnership Board is not a separate legal entity or a committee of any of the Partners when considering Partnership Business, therefore it is unable to take decisions separately from its constituent Members or bind any one of them; nor can one Partner organisation 'overrule' another on any matter. The Partnership Board will operate as a place for discussion of Partnership Business with the aim of reaching consensus to make recommendations and proposals to the boards of Partner organisations, unless the Members have the requisite delegated authority from their Partner organisations to make the relevant decision.
12	**Frequency of meetings**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Partnership Board determines otherwise and amends these terms of reference accordingly.
13	**Urgent decisions**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Partnership Board determines otherwise and amends these terms of reference accordingly.
14	**Admission of the press and public**	The Partnership Board may meet in private to consider Partnership Business. However, if it is also considering ICB Business then press and public will be admitted in accordance with the terms of reference for ICB Business.
15	**Declarations of interest**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Partnership Board determines otherwise and amends these terms of reference accordingly.
16	**Support to the Partnership Board**	The arrangements set out in the Terms of Reference for ICB Business shall apply unless the Partnership Board determines otherwise and amends these terms of reference accordingly.
17	**Authority**	The arrangements set out in the Terms of Reference for ICB Business shall apply in relation to: • investigations • commissioning of reports and surveys • obtaining legal or other independent professional advice unless the Partnership Board determines otherwise and amends these terms of

		reference accordingly. In addition, if the Partnership Board agrees additional requirements regarding the above, those requirements must be complied with. The Partnership Board has the sub-committees set out in the Terms of Reference for ICB Business. The Partnership Board is authorised to create and dissolve permanent workstreams and time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, the Partnership Board must set a clear scope and where appropriate deadline for completion for the workstream or group. Such workstreams or groups shall not be able to take decisions on behalf of the Partnership Board and shall not be formal sub-committees of the Partnership Board.
18	**Reporting**	The Partnership Board shall report to the boards/ senior management of Partner organisations in respect of Partnership Business. It does this through Members reporting back to their Partner organisations. The Partnership Board shall also report to the Health and Wellbeing Board for Barnsley. The Partnership Board will receive for information updates on the work of any of its task and finish groups or workstreams.
19	**Conduct of the Partnership Board**	Members of the Partnership Board will abide by the 'Principles of Public Life' (The Nolan Principles). The Partnership Board shall undertake an annual self-assessment of its own performance against these terms of reference. This self-assessment shall form the basis of an annual report from the Partnership Board to the Barnsley Health and Wellbeing Board.
20	**Amendments**	Any amendment to these terms of reference is Partnership Business. Any changes to these terms of reference must be approved by the Partnership Board.
21	**Review date**	These terms of reference shall be reviewed annually.

BARNSLEY PARTNERSHIP BOARD

PART 3: PARTNERSHIP BOARD – TERMS OF REFERENCE FOR ICB PLACE COMMITTEE (ICB BUSINESS)

1	**Name of committee**	The **Barnsley Place Partnership Board** is established as and operates as a committee of the NHS South Yorkshire Integrated Care Board ("**ICB**"), in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation when it is considering ICB Business (the "**ICB Place Committee**")
2	**General**	These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership and reporting arrangements of the ICB Place Committee and may only be changed with the approval of the ICB Board. The ICB Place Committee has no executive powers, other than those specifically delegated in these terms of reference. In these Terms of Reference the following capitalised terms are given the meaning set out in the NHS South Yorkshire Integrated Care Board Constitution as updated from time to time, unless the context otherwise requires: ● Constitution ● ICB ● Standing Order or Standing Orders Other capitalised terms have the meaning set out below: "**Chair**" means the chair of the ICB Place Committee "**ICB Business**" matters which are delegated to the ICB Place Committee in line with its purpose at paragraph 4 by the ICB for determination by the ICB Place Committee "**ICB Policies**" means any policy, process or procedure formally adopted by the ICB **"Member**" refers to a member of the ICB Place Committee as listed in paragraph 0 "**Participant**" refers to a participant of the ICB Place Committee as listed in paragraph 0 "**Partnership Board**" means the partnership board as described in the Place Agreement that also sits as the ICB Place Committee when conducting ICB Business "**Place Agreement**" means the Barnsley Place Agreement entered into by the Partners (including the ICB) for the transformation and better integration of health and care services for the population of Barnsley "**Working Days**" means a weekday that is not a bank holiday in England The ICB is part of the South Yorkshire Integrated Care System, which has four core purposes: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience and access • enhance productivity and value for money • help the NHS support broader social and economic development. The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including: • improving the health of children and young people • supporting people to stay well and independent • acting sooner to help those with preventable conditions • supporting those with long-term conditions or mental health issues • caring for those with multiple needs as populations age • getting the best from collective resources so people get care as quickly as possible.
3	**Reports to**	The ICB Board

4	**Purpose**	The ICB Place Committee will support the ICB in delivering its statutory and/or corporate functions as set out in paragraph 5.
5	**Remit and responsibilities**	The role of the ICB Place Committee will be to actively participate in the Barnsley Place Partnership in accordance with the Place Agreement, and in accordance with the Constitution of the ICB. The ICB Place Committee is responsible for: **Regulation and Control** • Establish governance arrangements to support collective accountability between partner organisations for place-based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations. **Strategy and Planning** • Agree a plan to meet the health and healthcare needs of the Barnsley population, having regard to the ICS integrated care strategy and Barnsley health and wellbeing strategies. • Ensure consultation, involvement and engagement on place plans is undertaken where appropriate • Engagement with Health Overview and Scrutiny Committee. • Develop Annual Plan for Delivery of Place Health & Wellbeing Strategy and ICP Strategy • Ensure provision of Health Care Services for Place Population. • Agree Place-based delivery plans. • Allocate resources to deliver the plan in Barnsley, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital). • Approve the operating structure in Barnsley. • Develop joint working arrangements with partners in place that embed collaboration and integration as the basis for delivery within the ICB plan. • Arrange for the provision of health services in line with the allocated resources across the ICS through a range of activities including: o convening and supporting providers at Place to lead major service transformation programmes to achieve agreed outcomes. o support the development of primary care networks (PCNs) as the foundations of out-of- hospital care and building blocks of place-based partnerships. Including through investment in PCN management support, data and digital capabilities, workforce development and estates. o working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. • Agree place action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care. • Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability. **Partnership working** • Agree joint working arrangements at Place that embed collaboration and integration as the basis for delivery of the Place plan. **Staffing and human resources**

		• Delivery of implementation in Barnsley of people priorities. **Risk management** • Make arrangements to implement in place ICB risk management arrangements.
6	**Members**	The Members of the ICB Place Committee when undertaking ICB Business are: Executive Place Director, ICB (Chair) Chief Nurse, Barnsley Place, ICB Chief Medical Officer, Barnsley Place, ICB Chief Finance Officer, Barnsley Place, ICB Independent Non-Executive Member, ICB The Chair of the ICB must approve the appointment of any Member of the ICB Place Committee and may remove any Member of the ICB Place Committee, acting always in accordance with the ICB Constitution
7	**Participants**	The following individuals will be invited to attend each meeting of the ICB Place Committee as Participants. Participants attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote. The Participants of the ICB Place Committee when undertaking ICB Business are: • Barnsley Hospital NHS Foundation Trust ("**BHNFT**") – Chief Executive • BHNFT – Chair • Barnsley Metropolitan Borough Council ("**BMBC")** – Leader of the Council • BMBC Chief Executive • BMBC Director of Public Health • Barnsley Healthcare Federation ("**BHF**") – Chief Executive • BHF – Chair • South West Yorkshire Partnership NHS Foundation Trust ("**SWYPFT**") – Chair • SWYPFT – Chief Executive • Barnsley Hospice - Chief Executive • Barnsley Voluntary Services - Chief Executive • Barnsley PCN - Chair or Chief Executive • Healthwatch - Chair ICB officers may request or be requested to attend the ICB Place Committee meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper. The Chair may invite such other Participants to attend any meeting of the ICB Place Committee as the Chair considers appropriate.
8	**Deputies**	With the permission of the Chair, Members of the ICB Place Committee may nominate a deputy to attend a meeting that they are unable to attend. Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. The deputy may speak on their behalf but may not vote. The decision of the Chair regarding authorisation of nominated deputies is final.
9	**Chair**	The meetings will be run by the Chair of the ICB Place Committee (as noted in paragraph 6 above). If the Chair is absent or is disqualified from participating by a conflict of interest, a member of the ICB shall be chosen by the members present, or by a majority of them, and shall preside. In the event of the Chair being unable to attend all or part of the meeting, another Member of the ICB Place Committee shall chair the meeting.

10	**Quoracy**	No business shall be transacted unless at least 60% of the ICB Place Committee membership (which equates to 3 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member For the sake of clarity: a) No person can act in more than one capacity when determining the quorum. b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum. Members of the ICB Place Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year
11	**Conduct of meetings**	In line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the ICB Place Committee will have one vote, the process for which is set out below: a) All members of the ICB Place Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, Members of the ICB Place Committee are set out at paragraph 6; Participants and observers do not have voting rights.) b) Absent Members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. c) For the sake of clarity, any additional Participants and Observers (as detailed within Section 5.6. of the Constitution) will not have voting rights. A resolution will be passed if more votes are cast for the resolution than against it. d) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote. e) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.
12	**Frequency of meetings**	The ICB Place Committee will meet monthly in common with the Partnership Board. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the ICB Place Committee. One third of the members of the ICB Place Committee may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting, If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the ICB Place Committee Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members of the ICB Place Committee specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

13	**Urgent decisions**	In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the ICB Place Committee to meet virtually. Where this is not possible the following will apply: a) The powers which are delegated to the ICB Place Committee may allow for an urgent decision be exercised by the Chair subject to every effort having made to consult with as many members as possible in the given circumstances. b) The exercise of such powers shall be reported to the next formal meeting of the ICB Place Committee for formal ratification, where the Chair will explain the reason for the action taken, and the ICB Audit Committee for oversight.
14	**Admission of the press and public**	In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the ICB at which public functions are exercised will be open to the public. This includes the Partnership Board where it is discussing ICB Business as the ICB Place Committee. The ICB Place Committee may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. The chair of the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the ICB Place Committee's business shall be conducted without interruption and disruption. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the ICB Place Committee. A public notice of the time and place of the meeting and how to access the meeting shall be given by posting it electronically at least 7 calendar days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. The agenda and papers for meetings will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.
15	**Declarations of interest**	If any Member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

16	**Support to the ICB Place Committee**	Administrative support will be provided to the ICB Place Committee by officers of the ICB. This will include: • Agreement of the agenda with the Chair, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward; • Maintaining an on-going list of actions, specifying Members responsible, due dates and keeping track of these actions; • Sending out agendas and supporting papers to Members five working days before the meeting. • Drafting minutes for approval by the Chair within five working days of the meeting and then distribute to all attendees following this approval within 10 working days; and • An annual work plan to be updated and maintained on a quarterly basis.
17	**Authority**	The ICB Place Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of the ICB and they are directed to co-operate with any such request made by the ICB Place Committee. The ICB Place Committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations. The ICB Place Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the ICB Place Committee must follow procedures put in place by the ICB for obtaining legal or professional advice. The ICB Place Committee is authorised to create sub-committees or working groups as are necessary to fulfil its responsibilities within its terms of reference. The ICB Place Committee may not delegate powers delegated to it within these terms of reference (unless expressly authorised by the ICB Board) and remains accountable for the work of any such group.
18	**Reporting**	The ICB Place Committee shall submit its minutes to each formal ICB Board meeting. The Chair shall draw to the attention of the ICB Board any significant issues or risks relevant to the ICB. The ICB Place Committee's minutes will be published on the ICB website once ratified. The ICB Place Committee shall submit an annual report to the ICB Audit Committee and the ICB Board. The ICB Place Committee will receive for information the minutes of other meetings which are captured in the ICB Place Committee work plan e.g. sub-committees.

19	**Conduct of the ICB Place Committee**	All Members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures. Members of the ICB Place Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. The Partnership Board (including the ICB Place Committee) shall agree an annual delivery plan with the ICB Board. The ICB Place Committee shall undertake an annual self-assessment of its own performance against the annual work plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the ICB Place Committee. Any resulting changes to the terms of reference shall be submitted for approval by the ICB Board.
20	**Amendments**	These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership and reporting arrangements of the ICB Place Committee and may only be changed with the approval of the ICB Board.
21	**Review date**	These terms of reference shall be reviewed annually.

BARNSLEY PLACE JOINT ICB & ADULT SOCIAL CARE SENIOR MANAGEMENT TEAM Terms of Reference	
Version	**2**
Implementation Date	**1 November 2022**
Review Date	**1 April 2023**
Approved By	**Barnsley Place Partnership Board (Place Committee)**
Approval Date	**27 October 2022**

VERSIONS			
Date	**Version**	**Comments**	**Author**
8 July 2022	**1.0**	Initial draft for feedback and comments for feedback	**Richard Walker/Roxanna Naylor**
18 August 2022	**1.1**	Draft revised to include reference to joint working arrangements with Place Health & Adult Social Care Directorate Management Team Meeting	**Richard Walker/Roxanna Naylor**
24 August 2022	**1.2**	Further amendments to more fully integrate the ICB and ASC elements into a single, coherent TOR.	**Richard Walker**
21 Sept 2022	**1.3**	Further amendments following feedback from colleagues to clarify status of SMT as a sub group of the Barnsley Place Committee; to clarify the distinction between formal and informal meetings; and to clarify method of reporting into the Place Committee.	**Richard Walker**
29 Sept 2022	**1.4**	Final amendments to clarify no delegated decision making to SMT, and minor changes to attendees	**Richard Walker**
13 Oct 2022	**1.5**	Quorum for Place Committee reduced from 4 members to 3 as agreed at SMT 6.10.22	**Richard Walker**
20 Oct 2022	**1.6**	Additional text re remit and responsibilities in relation to Adult Social Care in section 5	**Richard Walker**
8 Dec 2022	**2.0**	Final, clean version with watermark removed	**Richard Walker**

TERMS OF REFERENCE FOR BARNSLEY PLACE JOINT ICB & ADULT SOCIAL CARE SENIOR MANAGEMENT TEAM

1	**Name of committee**	The **Barnsley Place Joint ICB & Adult Social Care Senior Management Team** ('SMT') is established as and operates as a sub committee of the ICB Barnsley Place Committee.
2	**General**	These terms of reference set out the remit, responsibilities, membership and reporting arrangements of SMT, and may only be changed with the approval of the Board. The SMT has no executive powers, other than those specifically delegated in these terms of reference. The ICB is part of the South Yorkshire Integrated Care System, which has four core purposes: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience and access • enhance productivity and value for money • help the NHS support broader social and economic development.
3	**Reports to**	ICB Barnsley Place Committee (when conducting ICB Business). When considering Adult Social Care Business SMT reports key decisions through Cabinet process.
4	**Purpose**	SMT operates as a joint working group to enable the ICB Executive Place Director / Executive Director Adults & Communities effectively to discharge her responsibilities by coordinating the work of senior managers across health and adult social care, enabling them to work effectively together as a forum for the exchange of ideas and for identifying opportunities for collaboration and integrated working. SMT is operationally responsible for the conduct and delivery of matters delegated to the ICB Barnsley Place Committee when carrying out ICB Business as a committee of NHS South Yorkshire Integrated Care Board.
5	**Remit and responsibilities**	SMT is responsible for supporting the ICB Executive Place Director / Executive Director Adults & Communities to deliver her responsibilities across her entire remit. Specifically in relation to ICB Business SMT is responsible for: • Delivering the ask of the ICB in Barnsley Place, working alongside the Place Partnership Board • Providing assurance to the ICB Board and its assurance committees, via the ICB Place Committee • Operational management of the Barnsley Place team • Ensuring ICB business at place is conducted in compliance with all statutory and regulatory requirements and in accordance with ICB policies • Ensuring expenditure within the Barnsley Place is managed within the delegated allocation.

		Specifically with regards to Adult Social Care: • Delivery of responsibilities as defined within the Scheme of Delegation in accordance with BMBC constitution • Providing assurance of quality and improvement and overall efficacy of Adult Social Care to BMBC Senior Management Team and Cabinet. • Operational leadership of Adult Social Care.

	Members	Membership and attendance at SMT differs according to whether or not SMT is considering ICB or Adult Social Care Business. The table below sets out the status of individual representatives in each case for ease of reference:

Nominated Representative (Role/Title)	Organisation	Status for ICB Business	Status for Adult Social Care Business
ICB Executive Place Director / Executive Director Adults & Communities	NHS South Yorkshire ICB / BMBC	Member & Chair	Member & Chair
Chief Nurse, Barnsley Place	NHS South Yorkshire ICB	Member	Attendee
Medical Director, Barnsley Place	NHS South Yorkshire ICB	Member	Attendee
Chief Finance Officer, Barnsley Place	NHS South Yorkshire ICB	Member	Attendee
Chief Operating Officer, Barnsley Place	NHS South Yorkshire ICB	Member	Attendee
Director of Strategic Commissioning and Partnerships, Barnsley Place	NHS South Yorkshire ICB	Member	Attendee
Service Director, Adult Social Care & Well-Being	BMBC	Attendee	Member
Interim Service Director, Commissioning & Integration	BMBC	Attendee	Member
Strategic Finance Manager	BMBC	Attendee	Member
Service Director, Public Health and Regulation	BMBC	Attendee	Attendee
Communications Representative	BMBC	Attendee	Attendee
Head of Medicines Optimisation, Barnsley Place	NHS South Yorkshire ICB	Attendee	Attendee
Head of Comunications and Engagement, Barnsley Place	NHS South Yorkshire ICB	Attendee	Attendee
Head of Governance and Assurance, Barnsley Place	NHS South Yorkshire ICB	Attendee	Attendee

A joint working group does not have the authority collectively to make decisions. It is therefore anticipated that the meeting will operate as follows:

- Meetings will have 2 parts to the agenda, an ICB SMT section (Part 1) and an Adult Social Care DMT section (Part 2).

		• During Part 1 business will be conducted in accordance with these Terms of Reference. BMBC representatives listed above will attend and contribute to the discussion as appropriate but have no decision making or voting rights. • Conversely, during Part 2 the ICB SMT representatives (other than the Place Director / Executive Director Adults & Communities) will be in attendance but will have no decision making or voting rights in relation to the matters under discussion. • At the Chair's discretion, if there is any confidential ICB business to be transacted this will be taken at the start of Part 1 without BMBC members present. Similarly if there is any confidential ASC business to transact this will be taken at the end of Part 2, without ICB members present. The ICB Executive Place Director / Executive Director Adults & Communities will Chair both parts of the meeting and will determine the business to be conducted under both parts of the agenda. If she is unable to attend another member of ICB SMT will preside over Part 1 as per section 9 above, and another member of Adult Social Care DMT will preside over Part 2. ***For clarity the arrangements set out at sections 7 to 21 below apply specifically to ICB business conducted under Part 1 of the Agenda. It is anticipated that Part 2 (Adult Social Care) business will also be conducted in accordance with the same principles but any decisions taken would be in accordance with the Council's Constitution, Scheme of Delegation and Financial Regulations.***
7	**Attendees**	Other ICB officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper. The Chair may invite such other attendees to attend any meeting of SMT as the Chair considers appropriate.
8	**Deputies**	With the permission of the Chair, Members of SMT may nominate a deputy to attend a meeting that they are unable to attend. Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. The deputy may speak on their behalf but may not vote or count towards the quorum.
9	**Chair**	The meetings will be run by the Chair (as noted in paragraph 6 above). If the Chair is absent or is disqualified from participating by a conflict of interest, another member of SMT shall be chosen by the members present, or by a majority of them, and shall preside.

10	**Quoracy**	No ICB business shall be transacted unless at least half of the ICB Place Committee membership (which equates to three individuals) and including the following are present: One of the Executive Place Director or the Chief Finance Officer (Barnsley) When undertaking Adult Social Care business the meeting will be deemed to be quorate if at least 2 of the BMBC members, including at least one of the Executive Director Adults & Communities or the Strategic Finance Manager, are present. For the sake of clarity: a) No person can act in more than one capacity when determining the quorum. b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum. Members of SMT may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.
11	**Conduct of meetings**	When considering ICB business, in line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, at the discretion of the Chair, the matter will be: • Put to a vote of the members present, with each member present having one vote each,and the Chair having a casting vote in the event of a tie, or • Escalated to the ICB Barnsley Place Committee for resolution. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

12	**Frequency of meetings**	**Formal meetings** of SMT will be held monthly. These meetings will operate on a formal basis with agendas and papers being circulated a week in advance wherever possible. These meetings will consider and agree action in respect of more significant or complex matters, and will receive regular reports from Members in relation to their specific areas of responsibility, including but not limited to finance, performance and quality of commissioned services. In addition, **informal meetings** of SMT will be held weekly. These meetings will operate on a less formal basis, with greater flexibility at the Chair's discretion to allow late additions to the agenda and to accept reports in a variety of formats – verbal, written, powerpoint presentation etc. The purpose of these informal meetings is to allow the prompt consideration and resolution of routine operational matters, and to ensure ongoing effective coordination and communication across the wider Barnsley Place Team. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
13	**Urgent decisions**	In the case of urgent decisions and extraordinary circumstances, every attempt will be made for SMT to meet virtually. Where this is not possible the following will apply: a) The powers which are delegated to SMT may be exercised by either the Chair or Chief Finance Officer (Barnsley), plus at least one other member of SMT, subject to every effort having made to consult with as many members as possible in the given circumstances. b) The exercise of such powers shall be reported to the next formal meeting of SMT for formal ratification, where the Chair will explain the reason for the action taken.
14	**Admission of the press and public**	Meetings of SMT will be held in private.
15	**Declarations of interest**	If any Member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

16	**Support to SMT**	Administrative support will be provided to SMT by administrative officers of the ICB. For formal monthly meetings this will include: • Agreement of the agenda with the Chair, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward; • Maintaining an on-going list of actions, specifying Members responsible, due dates and keeping track of these actions; • Sending out agendas and supporting papers to Members five working days before the meeting. • Drafting minutes for approval by the Chair within five working days of the meeting and then distribute to all attendees following this approval within 10 working days; and • An annual work plan to be updated and maintained on a quarterly basis.
17	**Authority**	SMT is authorised to investigate any activity within its terms of reference. SMT is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations. SMT is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the SMT must follow procedures put in place by the ICB for obtaining legal or professional advice. SMT is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference but may not delegate powers delegated to it within these terms of reference. In accordance with the Place Committee's Terms of Reference no powers are formally delegated from the Committee to SMT, however the individual officers comprising the Membership of SMT are authorised to take decisions within their remit and in accordance with the ICB's operational scheme of delegation and associated budgetary limits. Any decisions taken outwith these limits (eg decisions with a financial consequence not covered by an existing budget) will be reported to the Place Committee for ratification.

18	**Reporting**	SMT shall submit a log of any decisions taken with a financial consequence or with implications for service provision to each ICB Barnsley Place Committee meeting. The Chair shall draw to the attention of the ICB Barnsley Place Committee any significant issues or risks relevant to the ICB. SMT will also: • Provide assurance reports to the ICB Barnsley Place Committee regarding the delivery of the tasks and functions delegated to it • Seek decisions and approvals from the ICB Barnsley Place Committee on all matters not delegated to SMT • Communicate matters requiring a coordinated response from partners to the Barnsley Place Partnership Delivery Group or its workstreams
19	**Conduct of SMT**	All Members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures. Members of SMT will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.
20	**Amendments**	These terms of reference set out the remit, responsibilities, membership and reporting arrangements of Barnsley Place ICB Senior Management Team and may only be changed with the approval of the ICB Barnsley Place Committee.
21	**Review date**	These terms of reference shall be reviewed annually.

BARNSLEY PLACE PARTNERSHIP DELIVERY GROUP Terms of Reference	
Version	**2**
Implementation Date	**1 November 2022**
Review Date	**1 April 2022**
Approved By	**Barnsley Place Partnership Board**
Approval Date	**27 October 2022**

VERSIONS			
Date	**Version**	**Comments**	**Author**
28.09.22	**1**	First Version	Jeremy Budd NHS South Yorkshire ICB - Director of Strategic Commissioning & Partnerships (Barnsley)
20.10.22	**2**	Revised version incorporating comments received	Richard Walker, Head of Governance & Assurance

TERMS OF REFERENCE FOR BARNSLEY PLACE BARNSLEY PLACE PARTNERSHIP DELIVERY GROUP

1	**Name of committee**	Barnsley Place Partnership Delivery Group	
2	**General**	1.1	Barnsley Metropolitan Borough Council (BMBC), Barnsley Hospital NHS Foundation Trust (BHNFT), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Barnsley Healthcare Federation (BHF) and NHS South Yorkshire ICB have, as partners, agreed to develop an integrated system of health and social care in Barnsley working with other partners including Barnsley CVS, Healthwatch Barnsley and Barnsley Hospice. This integrated system is referred to in these terms of reference, and in the Place Agreement that the above partners have signed up to, as an "Integrated Care Partnership" or "ICP". The Place Partnership Delivery Group (PPDG) will oversee and deliver the Priority Programmes as agreed by the Partners, in accordance with vision and objectives set out below and in the Place Agreement, and report to the Barnsley Place Partnership Board (when conducting Partnership business) on progress.
		1.2	Together we will develop a model for integrated services that joins up care around the mental, physical, and social needs of people. In doing so, we will help deliver the Barnsley health and care plan and ICP development plan.
		1.3	The Partners have agreed to work towards a common Vision for the Integrated Care Partnership (ICP), in Barnsley, as follows: *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy, and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*

		1.4	The Partners have agreed to work together in accordance with the Place Agreement in order to achieve the following Objectives: • Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each Partner delivering their part without duplication; • Individuals, families and communities are empowered to take control wherever possible of their own health and wellbeing; • Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance; • Embed integrated care that delivers the best value for the Barnsley pound; • Develop population health management approaches to improve health and wellbeing and reduce health inequalities; • Work towards becoming a thriving ICP in accordance with the ICP Development Plan for 2022/23 and beyond; and • Play a pivotal role in delivering our shared vision for Barnsley: a place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley
3	**Reports to**	Barnsley Place Partnership Board (when conducting partnership Business)	
4	**Purpose**	The purpose of the PPDG is to oversee and deliver the ICP priority programmes as agreed within Barnsley health and care plan and also overseeing delivery of the ICP development plan. Ensuring there is operational ownership of the agreed programme of work, agreeing where changes to the workplan need to be made and reporting progress and risks to delivery to the Barnsley Place Partnership Board (when conducting Partnership business).	
5	**Remit and responsibilities**	3.1	Act as a senior leadership delivery group for Barnsley; ensure operational issues are dealt with, act as a point of escalation from place operational teams and coordinate and deliver mutual aid
		3.2	Overseeing and delivering the Barnsley health and care plan and the ICP Development Plan.
		3.3	Regular reporting to Partner organisation boards on progress against the Barnsley health and care plan and the ICP Development Plan.

		3.4	Regular reporting to the Place Partnership Board on progress against the Barnsley health and care plan and the ICP Development Plan.
		3.5	Operating in accordance with the principles as set out within the Barnsley Place Agreement.
		3.6	Ensuring all risk is assessed and assuring that mitigating actions are in place
		3.7	Managing and utilising resources across the ICP to optimise service delivery.
		3.8	Working within the overall scope of the ICP, recognising that changes will be agreed during the course of its development and introduction. Where relevant make recommendations to the Place Partnership Board for changes to the Barnsley health & care plan.
		3.9	Supporting the Transformation and Enabling Programme boards to deliver their objectives and milestones as set out within the Barnsley health and care plan.
		3.10	Considering and agree issues raised by the programme boards within the remit of the PPDG.
		3.11	Overseeing and co-ordinating dependencies which exist across the ICP health and care plan
		3.12	Supporting Barnsley HWB in the formulation and delivery of its Plan

6	**Members**	The membership of the PPDG will be 1. Partner organisation rotation – Chair of the PPDG 2. Executive Director – Place Health and Adult Social Care 3. Finance representation from the Finance & Performance Working Group 4. Quality Representation from the Health and Care Quality and Safety Committee 5. BHNFT - Deputy CEO and Chief Delivery Officer 6. BHNFT – Director of Operations 7. BMBC - Director of Public Health and Communities 8. BMBC – Director of Children's Services 9. BHF – CEO 10. BHF – PCN Manager 11. SWYPFT - Director of Strategy / Deputy CEO 12. SWYPFT- Service Director 13. SWTPFT – Clinical Services Director 14. Barnsley Mental Health, LD and Autism Alliance (Independent Chair) 15. Healthwatch – Deputy Chair 16. Barnsley Hospice – CEO 17. Barnsley Community & Voluntary Services – CEO 18. NHS South Yorkshire - Director of Strategic Commissioning & Partnerships (Barnsley) 19. NHS South Yorkshire - Chief Operating Officer (Barnsley) Membership will be reviewed and adjusted by agreement of the members as necessary to ensure the ICP meets its responsibilities. Every effort will be made to seek consensus. With effect from 1 April 2022, the role of Chair of the PPDG will be rotated to another member of the PPDG as agreed by the members. This will be undertaken on an annual basis at the beginning of every financial year.
7	**Attendees**	Health and Care Plan SROs are required to be in attendance, if not already a named member above e.g. workforce, digital, estates). SROs may invite their Programme Managers to attend as required.
8	**Deputies**	Deputies may be nominated to attend, although there should be a clear and consistent intention to attend by each appointed member.

9	**Chair**	With effect from 1 April 2022, the role of Chair of the PPDG will be rotated to another member of the PPDG as agreed by the members. This will be undertaken on an annual basis at the beginning of every financial year The chair of PPDG cannot come from the same organisation as the chair of the Place Partnership Committee.
10	**Quoracy**	**Quoracy and Decision making** 1. The Group will be quorate when at least half of the membership is present. 2. The PPDG will operate as a forum for discussion with the aim of reaching consensus among the Partners. The PPDG is neither a separate legal entity, nor a joint committee of the Partners, and is therefore unable to take decisions separately to its Partner members or bind any one of them; nor can one Partner organisation 'overrule' another on any matter. 3. Each Partner organisation will delegate to its representative on the PPDG such authority as is agreed to be necessary in order for the PPDG to function effectively in discharging the responsibilities set out in these terms of reference. 4. Each Partner organisation will ensure that their representatives understand the status of the PPDG and the limits of the authority delegated to them. 5. Any organisation failing to send a representative for two consecutive meetings will be asked to confirm their commitment. 6. If PPDG is unable to reach consensus and make a decision it will refer to the Place Partnership Board for resolution.
11	**Conduct of meetings**	The PPDG shall conduct its business in accordance with national guidance and relevant codes of practice including the Nolan principles. All members are required to notify the Chair of any actual, potential, or perceived conflict of interest in advance of the meeting to enable appropriate management arrangements to be put in place.
12	**Frequency of meetings**	The PPDG will meet on a monthly basis at minimum.
13	**Urgent decisions**	The PPDG will make recommendations to the Place Partnership Board and is not a decision making group.

14	**Admission of the press and public**	Meetings of the PPDG will be held in private.
15	**Declarations of interest**	If any Member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	**Support to the Partnership Delivery Group**	Administrative support will be provided to the PPDG by administrative officers of the ICB. This will include: • Agreement of the agenda with the Chair, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward; • Maintaining an on-going list of actions, specifying Members responsible, due dates, and keeping track of these actions; • Sending out agendas and supporting papers to Members five working days before the meeting. • Drafting minutes for approval by the Chair within five working days of the meeting and then distribute to all attendees following this approval within 10 working days; and • An annual work plan to be updated and maintained on a quarterly basis.

17	**Authority**	The Barnsley Place Partnership Delivery Group is authorised to to investigate any activity within its terms of reference. The Barnsley Place Partnership Delivery Group is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations with the approval of the Place Partnership Board. The Barnsley Place Partnership Delivery Group is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary with prior approval from the Place Partnership Board. In doing, so, the Finance, Performance and Efficiency Group must follow procedures put in place by partner organisations or the ICB or for obtaining legal or professional advice. The Barnsley Place Partnership Delivery Group is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference but may not delegate powers delegated to it within these terms of reference.
18	**Reporting**	Formal minutes will be completed from the meeting. This is a private meeting between member organisations. However, in the interests of good governance and promoting transparency the minutes relevant to a wider public audience can be taken in the public section of the member organisation' sovereign Boards. The members of the PPDG are responsible for providing feedback on a regular basis to their member organisations' Boards/ relevant decision making bodies. PPDG will report on its activities monthly to the Place Partnership Board.
19	**Conduct of the Partnership Delivery Group**	The PPDG shall conduct its business in accordance with national guidance, and relevant codes of practice including the Nolan Principles
20	**Amendments**	These terms of reference set out the remit, responsibilities, membership, and reporting arrangements of the Barnsley Place Partnership Delivery Group and may only be changed with the approval of the Place Partnership Board.
21	**Review date**	The PPDG will review at least annually its own performance, membership, and terms of reference. These terms of reference and any resulting changes to the terms of reference or membership will be approved by the member organisations' Boards/relevant decision making bodies.

BARNSLEY PLACE FINANCE, PERFORMANCE AND EFFICIENCY GROUP Terms of Reference	
Version	**1.2**
Implementation Date	**25 November 2022**
Review Date	**31 March 2023**
Approved By	**Barnsley Place Partnership Board**
Approval Date	**24 November 2022**

VERSIONS			
Date	**Version**	**Comments**	**Author**
22 July 2022	**1**	Initial draft for feedback and comments Comments and feedback	**Roxanna Naylor** **Jamie Wike**
23 Sept 2022	**1.1**	Updated to reflect comments from partners	**Roxanna Naylor**
16 Nov 2022	**1.2**	Updated to reflect conversations at first meeting with Directors of Finance from across place	**Roxanna Naylor**

TERMS OF REFERENCE FOR BARNSLEY PLACE FINANCE, PERFORMANCE AND EFFICIENCY GROUP

1	**Name of GROUP/COMMITTEE**	The **Barnsley Place Finance, Performance and Efficiency Group** is established as and operates as a sub group of the Barnsley Place Partnership Board ('the Board').
2	**General**	These terms of reference set out the remit, responsibilities, membership and reporting arrangements of the Finance, Performance and Efficiency Group, and may only be changed with the approval of the Board. The Finance, Performance and Efficiency Group has no executive powers, other than those specifically delegated in these terms of reference. The ICB is part of the South Yorkshire Integrated Care System, which has four core purposes: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience, and access • enhance productivity and value for money • help the NHS support broader social and economic development.
3	**Reports to**	Barnsley Place Partnership Board (when conducting partnership Business)
4	**Purpose**	Operationally responsible for the conduct and delivery of matters of the Barnsley Partnership Board developing a plan for financial sustainability and supporting delivery of the health plan and place/ICB strategy.
5	**Remit and responsibilities**	The Finance, Performance and Efficiency Group is responsible for: • Developing a place financial strategy for the medium/long term to deliver financial sustainability with appropriate monitoring and reporting arrangements, with the group to identify opportunities to be agreed by the Partnership that are linked to the strategy and plan of the Place Partnership. • Providing the partnership and the ICB place Committee with a transparent overview of the financial position (cost base) across Barnsley with an open book approach. • Developing and agree the place budget and activity plan, recognising the statutory body status and governance arrangements within each organisation of the partnership. • Understanding, monitoring, measuring, and reporting actions on Barnsley Place constitutional and other required performance metrics. • Establishing and developing operational plans in line with NHS England planning requirements. • Identify through benchmarking and an improvement lens the development of potential efficiency, productivity gains and elimination of waste opportunities with targeted work programmes across place and system to support financial sustainability.

		• Supporting the programme workstreams to develop and monitor the outcome and activity objectives within plans, ensuring impact assessments are undertaken and clear outcomes are included within any programme of work. This includes reviewing all proposed plans and providing direction and support as required to programme leads. • Monitoring all programmes against the delivery and outcome milestones. • Ensuring lessons learnt from the development and implementation of programmes of work are captured and reported across the partnership.
6	**Members**	The Members of the Finance, Performance and Efficiency Group are: Chair - To be agreed on a rotational basis Chief Finance Officer, Barnsley Place, ICB Chief Operating Officer, Barnsley Place, ICB Nominated Performance, Intelligence, and business support representative Director of Finance - Barnsley Hospital NHS foundation Trust Director of Finance – South West Yorkshire Partnership Foundation Trust Director of Finance – Barnsley Metropolitan Borough Council
7	**Attendees**	Other officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper. The Chair may invite such other attendees to attend any meeting as the Chair considers appropriate.
8	**Deputies**	With the permission of the Chair, Members of group may nominate a deputy to attend a meeting that they are unable to attend. Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. The deputy may speak on their behalf and will count towards the quorum.
9	**Chair**	The meetings will be run by the Chair (as noted in paragraph 6 above). If the Chair is absent or is disqualified from participating by a conflict of interest, another member of the Finance, Performance and Efficiency Group shall be chosen by the members present, or by a majority of them, and shall preside.

10	**Quoracy**	No business shall be transacted unless at least one member from each partner organisation or nominated deputy of the membership (which equates to 4 individuals) are present, with at least one representative from each partner. Members of the Finance, Performance and Efficiency Group may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.
11	**Conduct of meetings**	It is expected that recommendations and actions will be reached by consensus. Should this not be possible, at the discretion of the Chair, the matter will be: • Escalated to the Place Partnership Board for resolution.
12	**Frequency of meetings**	Meetings of the Finance, Performance and Efficiency Group will be held monthly (to be reviewed after 6 months). In addition, working groups will be established to support the Finance, Performance and Efficiency Group to deliver its objectives as set out by the partnership. In emergency situations the Chair may call a meeting with five days' notice by setting out the reason for the urgency, but this is expected to be by exception only.
13	**Urgent decisions**	The Finance, Performance and Efficiency Group will make recommendations to the Place Partnership Board and is not a decision making group.
14	**Admission of the press and public**	Meetings of the Finance, Performance and Efficiency Group will be held in private.
15	**Declarations of interest**	If any Member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

16	**Support to the Finance, Performance and Efficiency Group (FPEG)**	Administrative support will be provided to the Finance, Performance and Efficiency Group by administrative officers of the ICB. This will include: • Agreement of the agenda with the Chair, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward; • Maintaining an on-going list of actions, specifying Members responsible, due dates, and keeping track of these actions; • Sending out agendas and supporting papers to Members five working days before the meeting. • Drafting minutes for approval by the Chair within five working days of the meeting and then distribute to all attendees following this approval within 10 working days; and • An annual work plan to be updated and maintained on a quarterly basis.
17	**Authority**	The Finance, Performance and Efficiency Group is authorised to investigate any activity within its terms of reference. The Finance, Performance and Efficiency Group is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations with the approval of the Place Partnership Board. The Finance, Performance and Efficiency Group is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary with prior approval from the Place Partnership Board. In doing, so, the Finance, Performance and Efficiency Group must follow procedures put in place by partner organisations or the ICB or for obtaining legal or professional advice. The Finance, Performance and Efficiency Group is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference but may not delegate powers delegated to it within these terms of reference.

18	**Reporting**	The Finance, Performance and Efficiency Group shall submit a highlight report to each Place Partnership Board meeting. The Chair shall draw to the attention of the Place Partnership Board any significant issues or risks relevant to the partnership or ICB. The Finance, Performance and Efficiency Group will also: • Provide assurance reports to the Place Partnership Board when carrying out business relating to the delivery of the tasks and functions delegated to it • Seek decisions and approvals from the Place Partnership Board when carrying out on all matters not delegated to the Finance, Performance and Efficiency Group • Communicate matters requiring a coordinated response from partners to the Barnsley Place Partnership Delivery Group or its workstreams
19	**Conduct of the Group**	All Members will have due regard to and operate within the Constitution of partner organisations, the ICB, standing orders, standing financial instructions and other financial procedures. Members will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.
20	**Amendments**	These terms of reference set out the remit, responsibilities, membership and reporting arrangements of the Finance, Performance and Efficiency group and may only be changed with the approval of the Place Partnership Board.
21	**Review date**	These terms of reference shall be reviewed initially six months following date of implementation and annually thereafter.

HEALTH AND CARE QUALITY AND SAFETY COMMITTEE BARNSLEY PLACE Terms of Reference	
Version	**Final_v12. 21 November 22**
Implementation Date	**10 November 2022**
Review Date	**Three months following implementation date**
Approved By	**Barnsley Place Partnership Board (including ICB Place Committee)**
Approval Date	**24 November 2022**

VERSIONS

Date	Version	Comments	Author
Jul 22	1	Initial draft collated from Doncaster & Barnsley CCGs QPSC TOR	Jayne Sivakumar
Jul 22	2	Comments received from Barnsley Place members	Various
Aug 22	3	Reviewed and further comments received	Jayne Sivakumar
Aug 22	4	Collation of comments and revised draft shared with Barnsley Place members	Jayne Sivakumar
Aug 22	5	Additional comments and members under sections 5 & 6	Various
Aug 22	6	Above changes incorporated	Jayne Sivakumar
Aug 22	7	Revised membership following Place Executive leadership meeting, section 6, page 5. SY ICB logo added.	Jayne Sivakumar
Aug 22	8	Reviewed and further comments received	Jayne Sivakumar
Sept 22	9	Reviewed and further comments made	Jayne Sivakumar
Oct 22	10	Reviewed and further amendments made	Jayne Sivakumar
Nov 22	11	Patient Safety Specialist added to members	Hamel Dhanak
Nov 22	11	Reviewed section 18 no further amendments	Richard Walker
Nov 22	12	Membership adjusted following comments at 10 Nov meeting	Hamel Dhanak

1	**Name of committee**	The **Integrated Health and Care Quality and Safety Committee (QSC)** is established to support the Barnsley Place Committee and the South Yorkshire Integrated Care Board (SY ICB) in discharging their duties and responsibilities, as set out in the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation and the Terms of Reference for the ICB Barnsley Place Committee.
2	**General**	These terms of reference set out the membership, remit, responsibilities, and reporting arrangements of QSC, and may only be changed with the approval of the Board. The QSC has no executive powers, other than those specifically delegated in these terms of reference. The ICB is part of the South Yorkshire Integrated Care System, which has four core purposes: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience, and access • enhance productivity and value for money • help the NHS support broader social and economic development.
3	**Reports to**	The Meeting will establish and align to appropriate reporting mechanisms into the Barnsley ICB Place Committee to ensure the ICB is fully sighted upon Quality and Safety issues and actions delivered under the auspices of the Barnsley Place team of the ICB.
4	**Purpose**	• Function as a collaborative and integrated Health and Care Quality and Safety Committee that includes all partners • Monitor patient, public and carer experience, intelligence and information, working with the Place Equality and Engagement Group • Set local priorities for quality and health and care outcomes at Place • Set clear quality standards and expected outcomes when planning, which are considered as part of performance management • Have clear system governance and accountability arrangements for quality • Provide assurance to the Place Partnership Board and ICB Board for areas within its remit. • Work together to ensure seamless pathways between commissioned services, including identifying and managing quality issues • Develop a just culture which is open, transparent, and continuously improving • Share intelligence on risks and emerging concerns relating to quality and safety across Place and wider as required • Have an identified improvement methodology • Develop the workforce knowledge on Quality systems and assurance • Identify and work with Champions in Quality to share knowledge
5	**Remit and responsibilities**	QSC is responsible for monitoring and improving the quality and safety of all services commissioned by SY ICB and being delivered in Barnsley or directly commissioned for Barnsley residents. The meeting will undertake the following functions on behalf of the Barnsley Place Partnership Board in accordance with the delegation to the Board by the ICB.

		Securing continuous improvement to the quality of services Seeking to ensure continuous improvement to the quality of services by methods including, though not exclusively: • Receiving regular reports regarding quality and safety legislative and contractual requirements including patient safety and clinical effectiveness data and taking mitigating action as necessary. • Developing and reviewing quality schedules for commissioned care. • Monitoring of continuous improvement in the quality of services. • Maintaining contractual meetings to review the clinical quality of care with providers for which the Committee has commissioning responsibility. • Receiving and acting upon reports from regulatory and other competent bodies and ensure action plans are delivered. • Identifying risks, receiving risk profiles of providers and monitoring actions taken, aiming to proactively identify early warnings of any failing services. • Cooperating with local statutory partnerships such as the Barnsley Safeguarding Children's Partnership (BSCP), Barnsley Safeguarding Adults Board (BSAB), Multi-Agency Public Protection Arrangements (MAPPA), and Multi-Agency Risk Assessment Conferences (MARAC), taking feedback and learning and identifying risk from these wider partnership meetings. **Other Duties** • Consider clinical policies and procedures within the functions of the Meeting as set out in its Terms of Reference with due regard to the emerging ICB Governance Structure. • Ensuring that significant clinical risks are identified and reported on the Risk Register and escalating to the ICB Assurance Framework where necessary aligning with reporting structures into the ICB. • Establishing Sub-Groups to assist in discharging delegated responsibilities of the Meeting as set out in its Terms of Reference. **Subgroups** The following meetings shall report directly to the Health and Care Quality & Safety Committee and the notes of these shall be recorded. A highlight template will be submitted to the H&C Q&S Committee BHNFT Quality Improvement Subgroup SWYPFT Quality Improvement Subgroup Care Homes and Home Care Quality Improvement Subgroup Primary Care Quality Improvement Subgroup Area Prescribing Committee

		Quality Improvement Subgroup for Adults and Children and Young People Social Care Barnsley Hospice Quality Improvement Subgroup **Education & Training** Through the quality schedules within contracts, practice visits and practice communications, promote appropriate education, support, and training to include assessment of competency, for persons who are employed, or who are considering becoming employed, in an activity which involves or relates to the provision of services as part of health services in England to assist the Secretary of State for Health in the discharge of his related duty.
6	**Members**	The members of QSC shall comprise: The Chair and Deputy Chair role will be rotated on a quarterly basis. • Medical Director, ICB Barnsley Place • Medical Director, BHNFT • Director of Nursing, BHNFT • Chief Nurse and Director of Quality and Professions, SWYPFT • Clinical Director, SWYPFT • Chief Nurse, ICB Barnsley Place • Chief Nurse, BHF • Head of Primary Care, ICB Barnsley Place • Executive Director of Children's Services, BMBC • Healthwatch Barnsley Representative • Service Director for Adult Social Care and Wellbeing, BMBC • Service Director Public Health & Regulation, BMBC • Service Director Commissioning & Integration, BMBC • Head of Medicines Optimisation, ICB Barnsley • Director of Nursing, Barnsley Hospice • Director of Governance and Quality, Barnsley Hospice • Head of Quality and Safety (DCN), ICB Barnsley Place • Head of Safeguarding (DCN), ICB Barnsley Place • Patient Safety Partner/Specialist Members of the Group have a collective responsibility for directing and overseeing the subgroups work. They will bring their professional expertise and experience into the group and programme delivery. The Group will encourage a shared learning approach, which involves: • Group discussions to share experiences and learning. • Topics for the agenda being generated by members of the group and guided by current and relevant topics. • All members would be encouraged to actively participate in meetings.

		• Between meetings the membership will be expected to contribute to and participate in the ongoing improvement work. This will be conducted virtually or face to face to ensure momentum on agreed priority areas. • The participants shall ensure that each of their representatives has equivalent delegated authority Any changes to the membership of the meeting must be approved by the ICB Barnsley Place Committee.
7	**Attendees**	Other individuals may be invited to attend for all or part of any meeting as appropriate when matters concerning their responsibilities are to be discussed or they are presenting a paper. The Chair may invite such other attendees to attend any meeting of QSC as the Chair considers appropriate. Members are required to attend four out of six scheduled meetings. Attendance will be monitored throughout the year and any concerns raised by the Chair with the relevant Member.
8	**Deputies**	With the permission of the Chair, Members of QSC may nominate a deputy to attend a meeting that they are unable to attend. Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. The deputy may speak on their behalf but may not vote or count towards the quorum.
9	**Chair**	The meetings will be run by the Chair (as noted in paragraph 6 above). If the Chair is absent or is disqualified from participating by a conflict of interest, the Deputy Chair will preside, if the Deputy Chair (as noted in paragraph 6) is not available, another member of QSC shall be chosen by the members present, or by a majority of them, and shall preside. The Chair and vice chair shall be appointed by the ICB Barnsley Place Partnership Board.
10	**Quoracy**	No business shall be transacted unless at least seven individuals of the Quality and Safety Committee membership and including the following are present: QSC Chair, or Vice Chair in the Chair's absence. For the sake of clarity: a) There would need to be a minimum of 2 ICB officers present including at least one of the ICB Chief Nurse or Medical Director b) No person can act in more than one capacity when determining the quorum. c) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

		If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal minutes, and no decisions may be taken by the non-quorate meeting of the Meeting. Members of QSC may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.
11	**Conduct of meeting**	All Members are expected to adhere to the ICB Constitution and Standards of Business Conduct and Conflicts of Interest Policy. • In circumstances where a potential conflict is identified the Chair of the Meeting will determine the appropriate steps to take in accordance with the ICB's Conflicts of Interest policy. This action may include, but is not restricted to, withdrawal from the meeting for the conflicted item or remaining in the meeting but not voting on the conflicted item. • All Members shall respect confidentiality requirements as set out in the ICB Constitution. • The Meeting will conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice including the Nolan Principles.
12	**Frequency of meetings**	Formal meetings of QSC will be held bi-monthly, at least six times a year at times which are consistent with the quality reporting cycle, and which enable it to efficiently discharge its duties. Extraordinary meetings may be called at the discretion of the Chair. Due to the transition date of July 2022 the committee will meet four times in 2022/23.
13	**Urgent decisions**	In the case of urgent decisions and extraordinary circumstances, the Chair of QSC in consultation with other members, may also act on urgent matters arising between meetings of QSC. Any exercise of such powers shall be reported to the next formal meetings of QSC for formal ratification, where the Chair will explain the reason for the action taken.
14	**Admission of the press and public**	Meetings of QSC will be held in private.
15	**Declarations of interest**	If any Member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

16	**Support to the Partnership Board**	Administrative support will be provided to QSC by administrative officers of the ICB. This will include: • Agreement of the agenda with the Chair, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward. • Maintaining an on-going list of actions, specifying Members responsible, due dates, and keeping track of these actions. • Sending out agendas and supporting papers to Members five working days before the meeting. • Drafting minutes for approval by the Chair within five working days of the meeting and then distribute to all attendees following this approval within 10 working days. • An annual work plan to be updated and maintained on a yearly basis.
17	**Authority**	QSC is authorised to investigate any activity within its terms of reference. QSC is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations. QSC is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the QSC must follow procedures put in place by the ICB for obtaining legal or professional advice. QSC is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference but may not delegate powers delegated to it within these terms of reference.
18	**Reporting**	QSC shall submit its minutes to the ICB Barnsley Place Partnership Board. The Meeting shall formally record any issues or concerns to be escalated to this Group and to the ICB Quality, Performance, Patient Involvement and Experience Committee. Recommendations and decisions arising from the work of the Meeting will be reported to the ICB Barnsley Place Partnership Board, ICB Place Committee and System Quality Group, as necessary. The Meeting will review and assess its effectiveness at six months following implementation in year one, and annually thereafter and report its findings to the ICB Barnsley Place Partnership Board and ICB Place Committee. It will do this by: • Reviewing its terms of reference. • Reviewing the attendance rate of Committee members. • Reviewing its work plan. • Reviewing its performance.

19	**Conduct of the Partnership Board**	All Members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures. Members of QSC will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.
20	**Amendments**	These terms of reference set out the remit, responsibilities, membership, and reporting arrangements of Quality & Patient Safety Committee and may only be changed with the approval of the Place Partnership Board.
21	**Review date**	The Meeting will review its terms of reference at three months following implementation in year one, and annually thereafter, or sooner as Place and ICB arrangements evolve and the attendance rate of Meeting members annually. Any resulting changes to the terms of reference or membership shall be submitted to the Barnsley Place Partnership Board for approval. **Last Reviewed: November 2022** **Next Review Due: 3 months following implementation**

BARNSLEY INVOLVEMENT AND EQUALITY GROUP BARNSLEY PLACE Terms of Reference	
Version	**Final_v3**
Implementation Date	**November 2022 (1st meeting)**
Review Date	**Six months following implementation date**
Approved By	**Barnsley Place Partnership Board (including ICB Place Committee)**
Approval Date	**27 October 2010**

VERSIONS

Date	Version	Comments	Author
Jul '22	1	Initial draft taken from existing ToR of Barnsley engagement, experience and equality group	Kirsty Waknell
Sept '22	1	Went to current Barnsley partner engagement and equality working group at Sept '22 meeting for review.	Kirsty Waknell
October '22	2	Incorporates comments from the Sept meeting including name change to reflect 'involvement' rather than engagement as the overarching term.	Kirsty Waknell
December '22	3	Final, clean version with watermark removed	Richard Walker

1	**Name of committee**	The **Barnsley Involvement and Equality group (BIEG)** is established to bring the voice of Barnsley people, carers and communities to the work of the Barnsley Place Partnership Board to influence decisions and improve outcomes.
2	**General**	These terms of reference set out the membership, remit, responsibilities, and reporting arrangements of BIEG. The BIEG has no executive powers and is an advisory and delivery group. The group will also carry out its role in line with Public Sector Equality Duty. The group operates within the South Yorkshire Integrated Care System, which has four core purposes: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience, and access • enhance productivity and value for money • help the NHS support broader social and economic development.
3	**Reports to**	The group reports into the Barnsley Place Partnership Board. Any items for escalation relating specifically to patient experience will continue to be formally reported into the Barnsley Quality and Safety committee. Any items relating to the discharging of statutory duties of individual partners will be taken through their relevant governance process.
4	**Purpose**	The purpose of this group is to: a) Ensure the voice of local people, carers and communities is embedded in the work of the Barnsley Place Partnership Board. b) Work in an integrated way with a shared ownership of a single overarching involvement and equality plan to support the Barnsley health and care plan. To achieve this, the group will: • Amplify what matters to local people, carers and communities in relation to their health and wellbeing through a range of methods to inform plans, policies and services/interventions. • Collectively agree, develop and deliver a shared Barnsley health and care involvement and equality plan. • Follow and champion the agreed involvement principles endorsed by the Barnsley Place Partnership Board. • Support delivery of the NHS South Yorkshire 'Start With People' people and communities strategy. • Work with programme boards to ensure there is a clear demonstration of the impact of involvement and equality work on policies and decisions made. • Provide involvement and equality guidance and advice to the partnership on any proposed changes to services in the Barnsley health and care plan to inform commissioning, planning and delivery decisions. • Work in line with engagement and equality, diversity and inclusion statutory requirements in relation to service developments and decisions. • Collectively discuss changes and challenges in a safe environment to enable the consideration of different responses or solutions.
5	**Remit and responsibilities**	BIEG is responsible for the development, delivery and oversight of the Barnsley health and care people, carers and communities involvement and equality plan.

		Supporting principles The group will work to the principles agreed to by the Barnsley Partnership Board: 1. Have a strong local focus and work on both strengths and solutions with local communities 2. Value equality and the diversity of local communities 3. Make sure information is accessible and jargon free 4. Ensure that everyone has a voice, and we listen and learn from our staff and communities 5. Involve the right people, at the right time and come to you 6. Keep it simple and be honest about what you can influence 7. Avoid repeating the same conversations 8. Be open and transparent with what we know and what we have done and why **Subgroups** This group has been developed from the Barnsley engagement, equality and experience group. That group also has membership from Barnsley College and Berneslai Homes with extended invites to colleagues from the police, etc. This group meets on a monthly basis, with the exception of those months the BIEG meets.
6	**Members**	The members of BIEG shall comprise: • Public Health Principal, Adults and Communities, BMBC (Current Chair) • Service Manager, Adult Social Care, BMBC • Voice and Participation Lead, Adult Social Care, BMBC • Head of Stronger Communities, BMBC • SEND Participation Officer, BMBC • Patient Experience and Engagement Manager, BHNFT • Head of Inclusion, BHNFT • Director of Strategic Commissioning and Partnerships, ICB (BPPB member) • Head of Communications, Engagement and Equality, ICB • Engagement Manager, ICB • Quality Lead, ICB • Marketing, Communication, Engagement and Inclusion Lead, SWYPFT • Equality and Involvement Manager, SWYPFT • Communications and Engagement Manager, BHF • BCVS (role TBC) • Barnsley Hospice (role TBC) • Manager, Healthwatch Barnsley (independent role) Members of the group have a collective responsibility for directing and overseeing the subgroups work. They will bring their professional expertise and experience into the group and programme delivery.

		The Group will encourage a shared learning approach, which involves: • Group discussions to share experiences and learning. • Topics for the agenda being generated by members of the group and guided by current and relevant topics. • All members would be encouraged to actively participate in meetings. • Between meetings the membership will be expected to contribute to and participate in the ongoing engagement and equality work. This will be conducted virtually or face to face to ensure momentum on agreed priority areas. The participants shall ensure that each of their representatives has equivalent delegated authority.
7	**Attendees**	Other individuals may be invited to attend for all or part of any meeting as appropriate when matters concerning their responsibilities are to be discussed or they are presenting a paper. The Chair may invite such other attendees to attend any meeting of BIEG as appropriate. Members are required to attend three out of four scheduled meetings. Attendance will be monitored throughout the year and any concerns raised by the Chair with the relevant Member.
8	**Deputies**	Members of BIEG may nominate a deputy to attend a meeting that they are unable to attend. Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. The deputy may speak on their behalf but may not vote or count towards the quorum.
9	**Chair**	The meetings will be run by the Chair. If the Chair is absent or is disqualified from participating by a conflict of interest, another member of BIEG shall be chosen by the members present, or by a majority of them, and shall preside. The Chair and vice chair shall be appointed by the Barnsley Place Partnership Board.
10	**Quoracy**	No business shall be transacted unless at least four individuals of the BIEG membership and including the following are present: BIEG Chair, or Vice Chair in the Chair's absence. For the sake of clarity: a) No person can act in more than one capacity when determining the quorum. b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum. If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal minutes, and no decisions may be taken by the non-quorate meeting of the Meeting.

11	**Conduct of meeting**	All Members are expected to adhere to the ICB Constitution and Standards of Business Conduct and Conflicts of Interest Policy. • The Meeting will conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice including the Nolan Principles.
12	**Frequency of meetings**	Formal meetings of BIEG will be held quarterly which will enable it to efficiently discharge its duties.
13	**Urgent decisions**	In the case of urgent decisions and extraordinary circumstances, the Chair of BIEG in consultation with other members, may also act on urgent matters arising between meetings of BIEG. Any exercise of such powers shall be reported to the next formal meetings of BIEG for formal ratification, where the Chair will explain the reason for the action taken.
14	**Admission of the press and public**	Meetings of BIEG will be held in private.
15	**Declarations of interest**	If any Member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	**Support to the Partnership Board**	Administrative support will be provided to BIEG by administrative officers of the ICB.
17	**Authority**	BIEG is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations. BIEG is authorised to create working groups as are necessary to fulfil its responsibilities within its terms of reference but may not delegate powers delegated to it within these terms of reference.
18	**Reporting**	BIEG shall submit its minutes to the Barnsley Place Partnership Board Recommendations and decisions arising from the work of the meeting will be reported to the Barnsley Place Partnership Board as necessary. The meeting will review and assess its effectiveness at six months following implementation in year one, and annually thereafter and report its findings to the Barnsley Place Partnership Board. It will do this by: • Reviewing its terms of reference. • Reviewing the attendance rate of group members.

		• Reviewing its work plan. • Reviewing its performance.
19	**Conduct of the Partnership Board**	All Members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures. Members of BIEG will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.
20	**Amendments**	These terms of reference set out the remit, responsibilities, membership, and reporting arrangements of Barnsley Involvement and Equality Group and may only be changed with the approval of the Barnsley Place Partnership Board.
21	**Review date**	The Meeting will review its terms of reference at six months following implementation in year one, and annually thereafter. Any resulting changes to the terms of reference or membership shall be submitted to the Barnsley Place Partnership Board for approval. **Last Reviewed: October 2022** **Next Review Due: 6 months following implementation**

6.7. 2022/23 Work Plan including 2023/24 Draft Work Plan

To Note

Presented by Sheena McDonnell

Board of Directors Public Work Plan
April 2022 - March 2023

Standing Agenda Item	Executive Lead	Presenter of the report	Action	07.04.22	09.06.22	04.08.22 (NM to chair)	06.10.22	01.12.22	02.02.23
Introduction									
Declarations of Interest	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Quoracy	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Approve	✓	✓	✓	✓	✓	✓
Action log	Sheena McDonnell Chair	Sheena McDonnell Chair	Review	✓	✓	✓	✓	✓	✓
Patient/Staff Story	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Note	✓ QI Staff	✓	✓	✓	✓	✓
Quality Improvement (QI) improvement works update: **to be added to April 2023**	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Note						
Culture									
Freedom to Speak Up Guardian Report	Steve Ned Director of Workforce	Jan Munford Freedom to Speak up Guardian	Assurance			✓		✓	
Freedom to Speak up Tool (6/12) –	Steve Ned Director of Workforce	Jan Munford Freedom to Speak up Guardian	Assurance			✓			
NHS Staff Survey 2021	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance	✓					
Head of Inclusion and Wellbeing Update (from the strategy session held on 06.01.22)	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance	✓					
Annual Guardian of Safe Working **(October 2023)**	Dr S Enright Medical Director	Dr S Enright Medical Director	Assurance						
Assurance									
Chairs log: Quality and Governance Committee(Q&G)	Jackie Murphy Director of Nursing & Quality	Kevin Clifford Chair of Q&G Non-Executive Director	Assurance/ Approval	✓ (23/2 & 23/3)	✓ (27/4 & 25/5)	✓ (29/6 & 27/7)	✓ (24/8 & 28/9)	✓ (26/10 & 23/11)	✓ (25/1/23)

Standing Agenda Item	Executive Lead	Presenter of the report	Action	07.04.22	09.06.22	04.08.22 (NM to chair)	06.10.22	01.12.22	02.02.23
Policy for approval: Supporting Individuals with a Learning Disability and/or Autism when accessing Acute Hospital Services	Jackie Murphy Director of Nursing & Quality	Ros Moore Chair of Q&G Non-Executive Director Jackie Murphy Director of Nursing & Quality	Assurance/ Approval	✓					
End of Life Annual Report	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance		✓				
Policy for approval: Cleaning Standards	Jackie Murphy Director of Nursing & Quality	Ros Moore Chair of Q&G Non-Executive Director Jackie Murphy Director of Nursing & Quality	Assurance/ Approval	✓					
Annual Statement of Fire	Bob Kirton Chief Delivery Officer/Deputy CEO	Bob Kirton Chief Delivery Officer/Deputy CEO	Assurance			✓			
ReSPECT Policy	Jackie Murphy Director of Nursing & Quality Simon Enright Medical Director	Kevin Clifford Non-Executive Director/Chair of the Committee (approved in Q&G November 2022)						✓	

Chairs Log: Finance & Performance (F&P) Annual Effectiveness Review	Chris Thickett Director of Finance	Stephen Radford Chair of F&P Non-Executive Director	Assurance	✓ (24/2 & 24/3)	✓ (28/8 & 26/5)	✓ (30/6 & 28/7) ✓	✓ (25/8 & 29/9)	✓ (27/10 & 24/11)	✓ (26/1/)
LED Lighting Scheme							✓		
Chairs Log: People Committee Annual Effectiveness Review Trust People Plan	Steve Ned Director of Workforce	Philip Hudson Non-Executive Director	Assurance	✓ (22/2)	✓ (26/4)	✓ (28/6)	✓ (27/9)	✓ (22/11)	✓ (24/1)
						✓			
			Assurance/ approve					✓	
Gender Pay Gap Report	Steve Ned Director of Workforce	Steve Ned Director of Workforce							✓
Chairs Log: Audit Committee Annual Effectiveness Review	Chris Thickett Director of Finance	Nick Mapstone Chair of Audit Committee Non-Executive Director	Assurance		✓ (20/4)	✓ (13/7)		✓ (12/10)	✓ (18/1/)
						✓			
Chairs Log: Barnsley Facilities Services (BFS)	Lorraine Christopher Managing Director of BFS	Sue Ellis Chair of BFS Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Executive Team Report and Chair's Log	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Assurance	✓	✓	✓	✓	✓	✓
Annual Report - Patient Advice and Complaints Service	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance/ Approval				✓		
Infection Prevention and Control Annual Report 2021/22 & Annual Programme 2022/23	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance/ Approval		✓				

Performance									
Integrated Performance Report (IPR)	Bob Kirton Chief Delivery Officer/Deputy CEO	Lorraine Burnett Director of Operations	Assurance	✓	✓	✓	✓	✓	✓
Update on Ambulance Handovers	Bob Kirton Chief Delivery Officer/Deputy CEO	Lorraine Burnett Director of Operations	Assurance	✓	✓	✓	✓	✓	✓
Update on Referral to Treat (RTT) and Diagnostics	Bob Kirton Chief Delivery Officer/Deputy CEO	Bob Kirton Chief Delivery Officer/Deputy CEO	Assurance						
Trust Objectives 2022/23 Progress Report:	Bob Kirton Chief Delivery Officer/ Deputy CEO	Bob Kirton Chief Delivery Officer/ Deputy CEO	Assurance	✓		✓		✓	✓
Winter Plans	Bob Kirton Chief Delivery Officer/Deputy CEO/ Lorraine Burnett Director of Operations	Bob Kirton Chief Delivery Officer/Deputy CEO/ Lorraine Burnett Director of Operations	Assurance				✓		
Quarterly Mortality Report	Simon Enright Medical Director	Simon Enright Medical Director	Assurance			✓			✓
Annual End of Life Report	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance	✓					
Maternity Services Board Measures Minimum Data Set (Ockenden Report) Midwifery Staffing Report: six monthly update	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance	✓	✓	✓	✓	✓	✓
Quarterly Perinatal Mortality Review Tool (PMRT)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance	✓			✓		
Ockenden Independent Maternity Review Barnsley Progress Against 7 Immediate and Essential Actions (IEA)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance	✓					
Clinical Negligence Scheme for Trusts (CNST) Maternity	Jackie Murphy	Jackie Murphy	Assurance						

Incentive Scheme(MIS) (presented at the Strategy Session 05/01/23)	Director of Nursing & Quality	Director of Nursing & Quality							
Annual Report of Workforce, Race and Equality Standard	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance				✓		
Annual Workforce Disability Equality Standard	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance				✓		
Annual Fit and Proper Person Test 2021/22	Sheena McDonnell Chair	Steve Ned Director of Workforce	Assurance			✓			
Annual Health and Safety Report	Bob Kirton Chief Delivery Officer/Deputy CEO	Bob Kirton Chief Delivery Officer/Deputy CEO	Assurance					✓(inc within Q&G Chairs log)	
Annual NHSE Emergency Core Prep Standards	Bob Kirton Chief Delivery Officer/Deputy CEO	Mike Lees Head of Resilience & Security	Assurance					✓ (inc within Q&G Chairs log)	
Annual Doctors Appraisal & Revalidation Report	Simon Enright Medical Director	Simon Enright Medical Director	Assurance				✓		
Health Education England Self-Assessment Return – *added to the Board Strategy Session for September 2022*	Jackie Murphy Director of Nursing/ Simon Enright Medical Director	Jackie Murphy Director of Nursing/ Simon Enright Medical Director	Assurance						
Annual Safe Guarding Children and Adults Report 2021/22	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance					✓	
Patient Experience Report (incorporating Annual In-patient survey results and action plan)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance		✓				
Standards of Business Conduct and Managing Conflicts of Interest: Secondary Employment – *April 2023*	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance						
Patient Safety Specialist (PSS) – *moved the Board Strategy Session*	Jackie Murphy Director of Nursing & Quality Simon Enright Medical Director	Tracy Church Clinical Governance Specialist Debbie Firth Patient Safety Lead	Assurance						

SYB Laboratory Integrated Management System (Pathology) Update	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Assurance		✓				
Cyber Security Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
Cyber Security Update (June 2023)	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance						
Information Governance Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
Governance									
Constitution Review	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Approve	April 2023					
Board Assurance Framework (BAF)	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓	✓	✓		✓	✓
Corporate Risk Register (CRR)	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓	✓	✓		✓	✓
Board Code of Conduct	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance					✓	
Bi-annual report of the use of the Trust seal (bi-annual)	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance				✓		
Annual Submission of the Board of Directors Register of Interest	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓					
Annual review of: • Standing orders (SOs) • Standing Financial Instructions (SFIs) • Scheme of Delegation	Chris Thickett Director of Finance / Angela Wendzicha Interim Director of Corporate Governance	Chris Thickett Director of Finance/ Angela Wendzicha Interim Director of Corporate Governance	Assurance	April 2023					

Terms of Reference for: • Audit • Q&G • F&P • People Committee (to come April 2023)	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance		✓				
Quality Accounts 2021/22	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance		✓				
Draft Code of Governance	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance			✓			
Standards of Business Conduct and Managing Conflicts of Interest Policy	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Review/Approve						✓
Benefits Realisation Papers Schedule of Return									
Paediatric Inpatient Redesign & Associate Nurse Workforce – to be presented as part of a story	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Lorraine Burnett Director of Operations	Approval					✓	
LED Lighting Scheme	Lorraine Burnett Director of Operations	Lorraine Burnett Director of Operations	Review/ Approval				✓		
Barnsley Hospital NHS Foundation Trust Children's Services Developments	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Assurance						✓
Business Case									
Mexborough Elective Orthopaedic Centre	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Review/Approve						✓
For Information									
Chair Report (under for information)	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
CEO Report (under for information)	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Note	✓	✓	✓	✓	✓	✓

Intelligence Report (under for information)	Ms E Parkes Director of Communications & Marketing	Ms E Parkes Director of Communications & Marketing	Assurance		✓	✓	✓	✓	✓
Barnsley Integrated Care Partnership Group (Verbal)	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Acute Federation (Verbal) including South Yorkshire & Bassetlaw (SY&B) Highlight Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Acute Federation Annual Report	Sheena McDonnell Chair Richard Jenkins Chief Executive	Sheena McDonnell Chair Richard Jenkins Chief Executive	Note			✓			
Integrated Care Board Update (Verbal) including: • Integrated Care Board Chief Executive Report • Place Board Committees Terms of Reference	Richard Jenkins Chief Executive Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Richard Jenkins Chief Executive Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Note Note	✓	✓	✓	✓	✓	✓ ✓
Any other Business									
Questions from the Governors regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Questions from the Public regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Board Observation Feedback	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	Emma Parkes	Ros Moore	Simon Enright	Stephen Radford	Bob Kirton	Philip Hudson
Work Plan 2022 - 2023	Mel Brown Interim Director of Corporate Governance	Mel Brown Interim Director of Corporate Governance	Note	✓	✓	✓	✓	✓	✓ (workplan for 23/24)

Trevor Lake Chair: Left the Trust in May 2022, Chaired April 2022 Trust Board

Board of Directors Public Work Plan: April 2023 - March 2024

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Introduction									
Apologies & Welcome	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Declarations of Interest	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Quoracy	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Approve	✓	✓	✓	✓	✓	✓
Action log	Sheena McDonnell Chair	Sheena McDonnell Chair	Review	✓	✓	✓	✓	✓	✓
Patient/Staff Story	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Note	✓	✓	✓	✓	✓	✓
Culture									
Freedom to Speak Up Guardian Report	Steve Ned Director of Workforce	Jan Munford Freedom to Speak up Guardian	Assurance	✓		✓		✓	
Freedom to Speak up Tool (6/12)	Steve Ned Director of Workforce	Jan Munford Freedom to Speak up Guardian	Assurance			✓			✓
NHS Staff Survey 2022	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance	✓					
Annual Guardian of Safe Working	Simon Enright Medical Director	Simon Enright Medical Director	Assurance				✓		
Assurance									
Chairs log: Quality and Governance Committee(Q&G)	Jackie Murphy Director of Nursing & Quality	Kevin Clifford Chair of Q&G/ Non-Executive Director	Assurance/ Approval	✓ (22/2 & 29/3)	✓ (26/4 & 24/5)	✓ (28/6 & 26/7) Annual Effectiveness Review	✓ (30/8 & 27/9)	✓ (25/10 & 29/11)	✓ (20/12 & 24/1/24)

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Chairs Log: Finance & Performance (F&P)	Chris Thickett Director of Finance	Stephen Radford Chair of F&P/ Non-Executive Director	Assurance	✓ (23/2 & 30/3)	✓ (27/8 & 25/5)	✓ (29/6 & 27/7) Annual Effectiveness Review	✓ (31/8 & 28/9)	✓ (26/10 & 30/11)	✓ (21/12 & 25/1/24)
Chairs Log: People Committee	Steve Ned Director of Workforce	Sue Ellis Chair of People/ Non-Executive Director	Assurance	✓ (28/3)	✓ (25/4)	✓ (27/6) Annual Effectiveness Review	✓ (26/9)	✓ (28/11)	✓ (23/1/24)
Chairs Log: Audit Committee	Chris Thickett Director of Finance	Nick Mapstone Chair of Audit Committee Non-Executive Director	Assurance		✓ (25/4)	✓ (12/6 & 12/7) Annual Effectiveness Review		✓ (11/10)	✓ (17/1/24)
Chairs Log: Barnsley Facilities Services (BFS)	Lorraine Christopher Managing Director of BFS	Sue Ellis Chair of BFS Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Executive Team Report and Chair's Log	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Assurance	✓	✓	✓	✓	✓	✓
Annual Report - Patient Advice and Complaints Service	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance/ Approval			✓			
Infection Prevention and Control Annual Report & Annual Programme	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance/ Approval		✓				
Quality Improvement (QI) improvement works update (follow up following patient story)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Note	✓					
Performance									

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Integrated Performance Report (IPR)	Bob Kirton Chief Delivery Officer/Deputy CEO	Lorraine Burnett Director of Operations	Assurance	✓	✓	✓	✓	✓	✓
Trust Objectives 2023/24 Progress Report:	Bob Kirton Chief Delivery Officer/ Deputy CEO	Bob Kirton Chief Delivery Officer/ Deputy CEO	Assurance	✓		✓		✓	✓
Winter Plans	Bob Kirton Chief Delivery Officer/Deputy CEO/ Lorraine Burnett Director of Operations	Bob Kirton Chief Delivery Officer/Deputy CEO/ Lorraine Burnett Director of Operations	Assurance				✓		
Quarterly Mortality Report	Simon Enright Medical Director	Simon Enright Medical Director	Assurance			✓			✓
Annual End-of-Life Report	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance		✓				
Maternity Services Board Measures Minimum Data Set (Ockenden Report)	Jackie Murphy Director of Nursing & Quality	Sara Collier-Hield Head of Midwifery	Assurance	✓	✓	✓	✓	✓	✓
Midwifery Staffing Report: six monthly update	Jackie Murphy Director of Nursing & Quality	Sara Collier-Hield Head of Midwifery	Assurance	✓					
Quarterly Perinatal Mortality Review Tool (PMRT)	Jackie Murphy Director of Nursing & Quality	Sara Collier-Hield Head of Midwifery	Assurance	✓			✓		
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme(MIS)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance						✓
Annual Report of Workforce, Race and Equality Standard	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance				✓		
Annual Workforce Disability Equality Standard	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance				✓		
Annual Fit and Proper Person Test 2022/23	Sheena McDonnell Chair	Steve Ned Director of Workforce	Assurance			✓			
Annual Health and Safety Report	Bob Kirton Chief Delivery Officer/Deputy CEO	Bob Kirton Chief Delivery Officer/Deputy CEO	Assurance			✓			

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Annual NHSE Emergency Core Prep Standards	Bob Kirton Chief Delivery Officer/Deputy CEO	Mike Lees Head of Resilience & Security	Assurance					✓	
Annual Doctors Appraisal & Revalidation Report	Simon Enright Medical Director	Simon Enright Medical Director	Assurance				✓		
Health Education England Self-Assessment Return – ***TBC***	Jackie Murphy Director of Nursing/ Simon Enright Medical Director	Jackie Murphy Director of Nursing/ Simon Enright Medical Director	Assurance						
Annual Safe Guarding Children and Adults Report 2021/22	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance						✓
Patient Experience Report (incorporating Annual In-patient survey results and action plan)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance		✓				
Standards of Business Conduct and Managing Conflicts of Interest: Secondary Employment	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance	✓					
Cyber Security Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
Cyber Security Update (June 2023)	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
Information Governance Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
Governance									
Constitution Review	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Approve	✓					
Board Assurance Framework (BAF)/Corporate Risk Register	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓	✓	✓		✓	✓
Board Code of Conduct	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance					✓	
Bi-annual report of the use of the Trust seal (bi-annual)	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance				✓		

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Annual Submission of the Board of Directors Register of Interest	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓					
Annual review of: • Standing orders (SOs) • Standing Financial Instructions (SFIs) • Scheme of Delegation	Chris Thickett Director of Finance / Angela Wendzicha Interim Director of Corporate Governance	Chris Thickett Director of Finance/ Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓					
Terms of Reference for: • Audit • Q&G • F&P • People Committee	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓					
Quality Accounts 2022/23	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance		✓				
Benefits Realisation Papers Schedule of Return									
Community Diagnostics Centre (Phase 1)	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive / Loraine Burnett Director of Operations	Review/ Approve	✓					
O Block Phase 2 (Ward 14/ANPN Refurbishment)	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive / Loraine Burnett Director of Operations	Review/ Approve	✓					
EPR Replacement Medway	Tom Davidson Director of ICT/ Chris Thickett Director of Finance	Tom Davidson Director of ICT/ Chris Thickett Director of Finance	Review/ Approve	✓					
For Information									
Chair Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
CEO Report	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Note	✓	✓	✓	✓	✓	✓
Intelligence Report	Emma Parkes	Emma Parkes	Assurance		✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
	Director of Communications & Marketing	Director of Communications & Marketing							
Barnsley Integrated Care Partnership Group (Verbal)	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Acute Federation (Verbal) including South Yorkshire & Bassetlaw (SY&B) Highlight Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Integrated Care Board Update (Verbal) including: • Integrated Care Board Chief Executive Report	Richard Jenkins Chief Executive/ Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Richard Jenkins Chief Executive/ Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Note	✓	✓	✓	✓	✓	✓
Any other Business									
Questions from the Governors regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Questions from the Public regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Board Observation Feedback	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	Jackie Murphy	Nick Mapstone	Chris Thickett	Hadar Zaman	Tom Davidson	Sue Ellis
Work Plan 2023 - 2024	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓

Strategic Objectives:

Best for Patients and the Public	We will provide the best possible care for our patients and service users. We will treat people with compassion, dignity and respect, listen and engage, focus on quality, invest, support and innovate.
Best for People	We will make our Trust the best place to work by ensuring a caring, supportive, fair and equitable culture for all.
Best for Performance	We will meet our performance targets, and continuously strive to deliver sustainable services.
Best Partner	We will work with partners within South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
Best for Place	We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health.
Best for Planet	We will build on our sustainability work to date and reduce our impact on the environment.

7. Any Other Business

7.1. Questions from the Governors regarding the Business of the Meeting

To Note

Presented by Sheena McDonnell

7.2. Questions from the Public regarding the Business of the Meeting

Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final.

In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Date of Next Meeting: Thursday 6 April 2023 at 09.30 am, via zoom